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	345132	A. BUILDING _____ B. WING _____	C 01/13/2023

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GREENHAVEN HEALTH AND REHABILITATION CENTER	801 GREENHAVEN DRIVE GREENSBORO, NC 27406

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E 000	Initial Comments A unannounced complaint investigation and recertification Survey was conducted on 1/9/23 through 1/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # TFQU11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 1/9/23 through 1/13/23. Intakes NC00195693, NC00196374, NC00196970, and NC00196937 were investigated. 2 of 7 complaint allegations were substantiated. Event ID # TFQU11. 2 of 7 complaint allegations were substantiated.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		2/15/23

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

Electronically Signed | 02/09/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to maintain the dignity of residents by not providing assistance with Activities of Daily Living (ADLs) when requested for 2 of 5 residents (Resident #19 and Resident #11) reviewed dignity. Resident #19 indicated she waited over 1 hour for her call bell to be answered and this made her feel ignored, bad, and resulted in the resident being tearful, and Resident #11 stated it made them feel mad. Finding included: 1. Resident #19 was admitted to the facility on 11/22/21 with diagnoses of hemiplegia and hemiparesis secondary to cerebral infarction,	F 550	Greenhaven Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Greenhaven Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further,	

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F 550	Continued From page 2 affecting right dominant side, chronic pain, and type 2 diabetes mellitus. A review of Resident #19's quarterly minimum data set (MDS) dated 10/28/22 identified Resident #19 as being cognitively intact. Resident #19's MDS also indicated that she needed extensive assistance with dressing. During an interview with Resident #19 on 01/09/23 at 1:28 pm she indicated the staff took a long time to help her with getting dressed. She indicated that she has waited over an hour just to get assistance with putting on her bra, pulling up her pants and to fastening her pants. Resident #19 indicated that because she can do a lot for herself, and when she asks for assistance from staff, they make her feel bad. During a second interview with Resident #19 on 01/13/23 at 2:38pm, Resident #19 revealed again on the morning of 01/13/23 she had the same problem waiting over an hour for staff to respond to her call bell to help her with getting dressed. She reported she had to use the phone to call another staff member. She explained that she got ahold of the Scheduler, who was not a Nursing Assistant, by phone to come and help her. Resident #19 stated, she also reported this information to that staff member this morning. Resident #19 indicated it made her feel bad and ignored. She stated, "I try to do as much as I can for myself, I use my stick (adaptive equipment that aides with reaching items) to help me, but I still need some help from staff." Resident #19 stated "I learned to do a lot for myself because I plan on getting out of here, I try not to get anyone in trouble, like today I did everything I could, and waited for someone to come help put my bra on	F 550	Greenhaven 526.43 Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights Resident #11 and Resident #19, a call light audit was completed by the Administrator on 1/31/23, any concerns noted were addressed immediately. Resident #11 and Resident #19 were interviewed by the Administrator on 2/7/23. On 2/7/23, the Social Worker and/or Activities Director initiated resident questionnaires with all alert and oriented residents regarding call bell response time and customer service. The Social Worker, Director of Nursing (DON) and/or Activities Director will address all concerns identified during the questionnaires to include addressing resident care needs when indicated and education of staff. Questionnaires will be completed by 2/8/23. On 2/7/23, the Staff Development Coordinator initiated an in-service with all nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and	

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F 550	Continued From page 3 and pull up my pants." Resident #19 indicated she normally activates her call bell and must wait over an hour. Resident #19 was observed to be very tearful when discussing having to wait on staff to assist her and stated, "she just wanted to get better and go home." During an interview with the Scheduler on 01/13/23 at 2:08pm, it was indicated that she had received several phone calls from Resident #19 on different occasions, because of having to wait a long time for the nursing assistants to help her with getting dressed. The Scheduler stated she went to the Resident's room and provided assistance. She indicated she had reported these concerns related to call bell response time to the nursing staff (unable to recall specific staff members) on several occasions. During an interview with Nursing Assistant (NA) #9 on 01/13/23 at 4:00pm, she indicated she was assigned to Resident #19 on 01/13/23 from 7am to 7pm and has worked with her resident before. She stated she has helped Resident #19 get dressed before when she called for assistance, and she also helped her today put her bra on and pull up her pants. NA #9 stated she asked Resident #19 if she needed help with anything else and the resident said no. She revealed no knowledge of Resident #19's concerns of waiting over an hour for assistance with getting dressed. NA #9 indicated that she answered residents' call bells between 10 to 15 minutes of residents activating their bells. An interview was conducted with the Unit Manager on 01/13/23 at 4:15pm, and she indicated Resident #19 had reported concerns of not getting assistance from staff when needed.	F 550	admission staff regarding Call Lights and Customer Service with emphasis on all staff are responsible to address call lights timely and/or obtain appropriate staff for assistance if unable to meet resident needs. In-service will be completed by 2/10/23. After 2/10/23, any nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff who have not worked or received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff will be in-serviced during orientation regarding Call Lights. 10 resident call lights will be completed by the Administrator/Director of Nursing 3 times weekly x 1 week, then 1-time weekly x 1 month utilizing the Call Light Audit Tool. This audit is to ensure all staff stop to address call lights timely and/or obtain appropriate staff if unable to meet resident needs. The Administrator will address all concerns identified during the audit to include addressing resident needs and/or re-training of staff. The Director of Nursing will review the Call Light Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed.	

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F 550	Continued From page 4 She was unable to remember when this was reported or how many times the resident had reported this but she indicated it was more than once. The Unit Manager indicated when it was reported to her, she had verbally counseled the staff but did not document it. During an interview with the Director of Nursing on 01/13/23 at 5:00 pm she indicated that her expectation was for staff to answer call bells within 3-5 minutes and treat all residents with respect and dignity, that no residents should be waiting long periods of time for assistance with Activities of Daily Living. She further indicated that she was a new DON at the facility and she was unaware of any concerns with call bell response time. 2. Resident # 11 was admitted on 10/10/18. A review of Resident #11's quarterly minimum data set (MDS) assessment dated 11/8/22 identified Resident #11 as being cognitively intact. Resident #11's MDS also indicated that she needed total care with all activities of daily living. During an interview with Resident #11 on 1/9/23 at 10:50am she indicated the staff take (unable to recall specific staff) 45 minutes to an hour to answer her calls for assistance with needs such as getting her a drink or pulling her up in the bed. Resident #11 indicated that she was not able to do these things for herself and that it made her mad to have to wait for assistance. She further revealed that she has made nursing staff aware of this concern. An interview was conducted with Nursing Assistant #2 on 1/11/23 at 12:27pm. She revealed that she was assigned to Resident #11	F 550	The Administrator/Director of Nursing will present the findings of the Call Light Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Call Light Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 2/15/23	

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F 550	Continued From page 5 frequently and she had previously made her aware of her concern regarding call light response. She explained that when the concerns were reported to her by Resident #11 the needs had already been addressed. NA #2 was unable to recall when Resident #11 informed her of this issue. She indicated she had not relayed this issue to anyone else. An interview was conducted with Nurse #2 on 1/13/23 at 2:00pm. She revealed she worked with Resident #11 frequently and that she had not been made aware of Resident #11's concern regarding poor call light response times. An interview was conducted with the Director of Nursing on 01/13/23 at 02:50 PM. She revealed that she has not been made aware of any call light response time concerns for Resident #11 and her expectation was that staff respond to call lights for assistance within 3-5 minutes.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		2/15/23

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F 578	Continued From page 6 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to accurately document advanced directives throughout the medical record for 1 of 29 residents (Resident #64) reviewed for advanced directives. The findings included: Resident #64 was admitted to the facility on 4/20/22 and readmitted on 8/25/22. The medical record indicated Resident #64 was transferred to the hospital on 8/23/22 and she	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate Adv Directive On 1/10/23, the Social Worker reviewed and updated resident #64 desire for advance directive and code status. The resident care plan was updated to reflect desired advance directive and code status. On 2/7/23, the Social Worker/Assistant Director of Nursing (ADON) initiated an audit of 100% resident orders for advance directive/code status. This audit is to	

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F 578	Continued From page 7 was readmitted to the facility on 8/25/22. A progress note dated 8/31/22 written by the Social Worker revealed a care plan meeting with Resident #64 was held and the resident wanted to remain a full code. A review of Resident #64's quarterly Minimum Data Set (MDS) dated 11/15/22 revealed Resident was cognitively intact. The active care plan related to code status was initiated on 4/22/22 and revealed Resident #64 had chosen a code status of DNR (do not resuscitate). Resident #64's active physician orders included an order dated 8/25/22 for CPR (cardiopulmonary resuscitation) full code status. On 1/10/23 at 2:26 PM an interview was conducted with Resident #64 and she it indicated if her heart stopped beating, she wanted to be revived. Resident #64 stated, "yes I talked to someone when I came back from the hospital, and I told them I wanted to be revived." An interview on 1/10/23 at 3:51pm was conducted with the Social Worker and she indicated she had completed Resident #64's code status care plan and it was inaccurate. She indicated it should have been a full code not a DNR. During an interview with the Director of Nursing on 1/13/23 at 4:37 pm, she indicated the Resident's wishes should be honored and the advanced directives throughout the medical record would be accurate.	F 578	ensure the Social Worker reviewed with the resident and/or resident representative the desired advance directive/code status, the physician was notified of desired advance directive/code status, an order placed in the electronic record, the care plan updated to reflect resident desired advance directive/code. The Social Worker will address all concerns identified during the audit to include notification of the physician of desired advance directive/code status and updating electronic record when indicated. The audit will be completed by 2/10/22. On 2/6/22, the Facility Consultant completed an in-service with the Social Worker, Admission Director and Director of Nursing regarding Advance Directives with emphasis on ensuring the nurse and social worker reviews advance directives with the resident and/or resident representative upon admission, notify the physician of desired advance directive/code status, obtaining an order for code status and updating the electronic record/care plan. The Social Worker will review advance directives quarterly during the care plan meeting to ensure the resident/resident representative have not expressed a desire to change the Code Status. All newly hired social workers, admission director and/or Director of Nursing will be in-serviced during orientation regarding Advance Directives. On 2/7/23, the Staff Development Coordinator initiated an in-service with all	

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F 578	Continued From page 8 The Administrator was interview on 1/13/23 at 4:39 pm and she indicated she expected the advanced directives throughout the medical records and care plans to be accurate.	F 578	nurses regarding Advance Directives with emphasis on reviewing advance directives with the resident and/or resident representative upon admission, notification of the physician of desired advance directive/code status, obtaining an order for code status, updating the electronic record/care plan and ensuring a golden rod advance directive form in placed in the resident chart when indicated. In-service will be completed by 2/10/23. After 2/10/23, any social worker, admission director and/or nurse who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired social workers, admission director and/or nurse will be in-serviced during orientation regarding Advance Directives. The Medical Records Director, Minimum Data Set Nurse, Staff Development Coordinator and/or Director of Nursing will review all admissions during Interdisciplinary Team Meeting (IDT) 5 times a week x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to ensure that the Social Worker, Admission Director and/or nurse reviewed advance directive/code status with the resident and/or resident representative upon admission, the physician was notified of desired advance directive/code status, an order was placed in the electronic record and that the care plan was updated to reflect resident desired advance directive/code status. The Director of Nursing will review the Advance Directive Audit Tool 5 times a	

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F 578	Continued From page 9	F 578	week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will forward the results of the Advance Directive Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 2/15/23	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		2/15/23

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F 582	Continued From page 10 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) Form Centers for Medicare Services for 2 of 3 sampled residents reviewed for beneficiary protection notification review	F 582	F582 Medicaid/Medicare Coverage/Liability Notice On 1/13/23 the Senior Administrator for Western Region conducted an in-service on Skilled Nursing Facility Advance	

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F 582	Continued From page 11 (Resident # 11 and Resident #34). Findings included: 1.Resident #11 was admitted to the facility on 10/10/18. A review of the medial record revealed a CMS-10123 Notice of Medicare Non-Coverage Letter (NOMNC) was issued on 11/15/22 to Resident #11 which explained Medicare Part A coverage for skilled services would end on 11/17/22. The form further revealed that the facility initiated the discharged from Medicare Part A services when benefit days were not exhausted. Resident #11 resided in the facility at the time of the survey was being performed from 1/9/23-1/13/23. The medical record review further revealed that the CMS-10055 Skilled Nursing Facility Advanced Beneficiary notice (SNF-ABN) was not completed. 2. Resident # 34 was admitted to the facility on 9/20/22 A review of the medial record revealed a CMS-10123 Notice of Medicare Non-Coverage Letter (NOMNC) was issued on 10/31/22 to Resident #34 which explained Medicare Part A coverage for skilled services would end on 11/03/22. The form further revealed that the facility initiated the discharged from Medicare Part A services when benefit days were not exhausted. Resident #34 resided in the facility at the time of the survey was being performed from 1/9/23-1/13/23. The medical record review further revealed that the CMS-10055 Skilled Nursing Facility Advanced Beneficiary notice (SNF-ABN) was not completed. An interview was conducted with the Business Office Manager (BOM) on 1/13/22 at 11:10am.	F 582	Beneficiary Notice of Non-Coverage (SNF-ABN) for the Business Office Manager (BOM), Social Worker, Admissions Director for resident #11 and #34 due to not receiving an SNF-ABN as required. On 1/13/23 the Business Office Manager (BOM), Social Worker (SW) and Administrator audited 100% of all Medicare residents to ensure an SNF-ABN/Notice of Medicare Non-Coverage was issued properly and accurately. If any negative findings were found they were corrected immediately by the Business Office Manager, Social Worker and Administrator. On 2/7/23, the Facility Consultant in-serviced the Administrator, Director of Nursing, Business Office Manager, Social Worker, Admissions Director on Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN). The process for issuing the SNF-ABN to the resident/resident representative notifying them of the discontinuation of Medicare coverage for services and shift potential financial liability to the beneficiary. The Business Office Manager will audit using the Beneficiary Notice-Residents Discharged Within the last 6 months monthly x 4 months, using Beneficiary Notice-Residents Discharged Audit Tool. This audit is to ensure all Medicare residents being discharged from skilled benefits will receive the SNF-ABN/NOMNC as required and	

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F 582	Continued From page 12 She revealed that the BOM was responsible for issuing the NOMNC and the social worker is responsible to issue the SNF-ABN forms. An interview was conducted with the Social Worker on 1/13/23 at 11:16am. She revealed that she was just notified by the BOM on 1/12/23 that she was responsible for issuing the SNF-ABN notices so Residents #11 and #34 did not receive the SNF-ABN notices. An interview was conducted with the Administrator on 1/13/22 at 11:57am. She revealed that she was a new and unsure of the company's policy regarding Beneficiary notices and would follow up. An interview with the Senior Administrator assisting in the survey was conducted on 1/13/23 at 12:42pm. She revealed that it has been determined that the SNF-ABN notices have not been done and have initiated a plan of correction by in-servicing the social worker and initiating a performance plan.	F 582	informed of the residents/resident's representative rights to appeal. The Business Office Manager will forward the results of the Beneficiary Notice-Residents Discharged to the Quality Assurance Performance Improvement Committee (QAPI) x 2 months. The QAPI Committee will meet monthly x 2 months and review the Advance Directive Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		2/15/23

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F 607	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to report an injury of unknown origin (right femur fracture) when notified of an allegation of injury of unknown origin for 1 of 4 sampled facility reported allegations (Resident #61). The previous Administrator become aware of the injury of unknown origin while conducting an audit on 09/28/22 and realized the allegation of injury of unknown origin for Resident #61 had not been reported to the Division of Health Service Regulation as required. Findings included: The facility's abuse policy dated 10/15/22 read in part: "The facility will thoroughly investigate and document all allegations of resident abuse or neglect, misappropriation or facility property, diversion of drugs belonging to a resident or facility and fraud against a resident or facility. The Administrator will ensure for all allegations that involves abuse or results in serious bodily injury, the Division of Health Service Regulation, Health Care Personnel Section, and Adult Protective Services are notified immediately but no later than 2 hours after the allegation received, and determination of alleged abuse is made. For all allegations that do not involve abuse or result in serious bodily injury, the Administrator will ensure that the Division of Health Service Regulation, Health Care Personnel Section, and other appropriate agencies are notified no later than 24 hours. A written report must be sent to Health Service Regulation, Health Care Personnel Section within five (5) working days of the date the facility become aware of the alleged incident." The part of policy dated 10/15/22 for "injuries of	F 607	F607 Develop/Implement Abuse/Neglect Polices Resident #61 had an injury of unknown origin which was not reported timely. The resident recovered from the injury with no further complications from the injury. The resident is no longer at the facility as of 1/30/23. On 2/2/23 skin assessments were completed on all non-alert and oriented resident for signs and symptoms of abuse by the assigned nurse. All identified areas of concern will be investigated by the Director of Nursing Services. On 2/2/23 interviews were completed with all alert and oriented residents about abuse by the Social Worker. All identified areas of concern will be addressed through the resident concern and abuse process as necessary by the Administrator. On 2/7/23 education was completed with all alert and oriented residents by the Activities Director about abuse, including the definitions, resident rights, what to do in an abusive situation, and how to report abuse. On 2/7/23 an abuse questionnaire was started with all employees by the Staff Development Director (SDC) with question including, “Do you know of any resident that you witnessed or that has verbalized abuse to you that has not been	

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F 607	Continued From page 14 unknown source read as followed: "an injury should be classified as an "injury of unknown source" when all of the following criteria are met: The source of the injury was not observed by any person: AND The source of the injury could not be explained by the resident: AND The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time, or the incidence of injuries over time." During an interview with the previous Assistant Director of Nursing (ADON), (who was employed in the facility in August 2022) on 01/13/23 at 6:17 pm, she indicated she was made aware of the allegation on 08/26/22. The previous ADON indicated Resident #61 was seen by the Nurse Practitioner for pain and an x-ray was ordered and results revealed Resident #61 had a fracture right femur. She indicated she did not report this allegation to the Administrator, but she reported it to the Director of Nursing on 08/26/22. During an interview with the previous Director of Nursing (who was employed in the facility in August 2022) on 01/13/23 at 6:24 pm she indicated that she did not recall reporting the incident to the Administrator because the resident was sent out to the hospital once the x-ray results revealed the Resident had a fracture. During an interview with the previous Administrator (who was employed in the facility in August 2022) on 01/13/23 at 6:29 pm, she indicated she was not aware of the incident until she conducted a chart audit on 09/28/22. She indicated she submitted an initial allegation report	F 607	reported and addressed?" All identified areas of concern will be addressed through the resident concern and abuse process as necessary by the Administrator. On 2/7/23 quizzes were started with all employees to ensure successful understanding of the education on recognizing and preventing abuse and neglect. Any staff that does not pass the quiz after 3 attempts will not be allowed to work until they are reeducated and successfully pass. On 2/7/23 all employee files were audited by the Human Resources manager to ensure the files had background checks, reference checks, Health Care Personal Registry (HCPR) check on hire, and abuse education on hire. On 2/7/23 the Human Resources manager completed a current check of the health care personnel registry for all employees to ensure there were no substantial findings. On 2/7/23, 100% of grievances completed in last 30 days were reviewed by the Administrator to ensure all reportable allegations were reported to the Health Care Personal Registry (HCPR) and investigated. There were no identified areas of concerns. On 2/7/23 Progress notes were reviewed from 30 days for documentation of reportable allegations. There were no other reportable allegations noted. On 2/7/23, the Unit Coordinators posted the abuse action checklist on bright colored paper for nurses to use as a reference during allegations of abuse.	

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F 607	Continued From page 15 to the state at that time. A review of the initial allegation report revealed the date of the allegation of an injury of unknown source was on 8/26/22 and the report was submitted to the state on 09/28/22. An interview was conducted with the current Administrator on 01/13/23 at 7:15 pm, and she indicated it was her expectation to follow the facility's abuse policy and the state regulation for reporting any allegation of abuse, and injury of unknown origin with serious bodily injury, within the required timeframe of 2 hours.	F 607	On 2/2/23 an in-service was started with all nurses, nursing assistants, social worker, accounts payable, accounts receivable, therapy staff, housekeeping staff, activity staff, maintenance staff, receptionist, supply clerk, medical records and admission staff on the abuse and neglect policy by the The Staff Development Coordinator (SDC). On 2/7/23 an in-service was started with nurses about the action checklist for allegations of abuse. All in-services will be completed on 2/10/23. After 2/10/23, all staff to include agency and contract staff that have not worked and received the in-service will complete upon their next scheduled shift. This in-service will be included in orientation upon hire. On 2/7/23 all abuse allegations for the last three (3) months were reviewed for trends and patterns by the Director of Nursing. All risk management reports for the last 30 days will be reviewed by the Director of Nursing, for any possible injury of unknown origin that has not been reported. Any negative findings will be immediately addressed by the Director of Nursing and Administrator. The Director of Nursing will forward the results of the Abuse Allegation Audit to the Quality Assurance Performance Improvement Committee (QAPI) x 2 months. The QAPI Committee will meet monthly x 2 months and review the Abuse Allegations Audit to determine trends and / or issues that may need further interventions put into place and to	

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F 607	Continued From page 16	F 607	determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 2/15/23	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		2/15/23

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F 656	Continued From page 17 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to develop and implement a comprehensive care plan with measurable objectives and interventions in the areas of oxygen therapy and nutrition for 2 of 7 sampled residents. (Resident # 17 and # 62). Findings included: 1. Resident # 17 was admitted to the facility on 9/21/21 with diagnoses that included respiratory failure, congestive heart failure and stroke. Review of Resident # 17's physician orders dated 8/16/22 revealed supplemental oxygen to be delivered at 4 liters per minute via nasal cannula at bedtime for acute and chronic respiratory failure. Review of the quarterly Minimum Data Set (MDS) assessment dated 11/18/22 revealed Resident # 17 was cognitively intact and utilized supplemental oxygen therapy. Review of Resident # 17's comprehensive care plan last updated on 9/8/22 revealed supplemental oxygen therapy was not included.	F 656	F656 Develop/Implement Comprehensive Care Plan Resident #17 and #62 care plans have been updated, for #17 oxygen and #62 nutritional needs, weight loss and therapeutic diet. On 1/18/23 the Registered Dietitian (RD) and Dietary Manager (DM) initiated an audit of all resident care plans to ensure the care plan is updated for nutrition, risk of weight loss and therapeutic diet. The Registered Dietitian and Dietary Manager will address all concerns identified during the audit to include assessment of nutritional needs, weight loss and correct therapeutic diet updating care plan when indicated. The audit was completed on 1/18/23. On 2/6/23 the Minimum Data Set (MDS) Nurse and the MDS Consultant audited all residents with Oxygen physician orders to ensure Oxygen was care planned. If Oxygen was not care planned the MDS Nurse and MDS Consultant added Oxygen to the care plan at the time of the	

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F 656	Continued From page 18 On 1/12/23 at 12:06 PM an observation of Resident # 17 revealed current use of supplemental oxygen via nasal cannula. During an interview on 1/13/23 at 3:00 PM with the nurse unit manager (Nurse # 2), she revealed the unit managers were responsible for updating comprehensive care plans as needed. Nurse # 2 was not aware that Resident # 17's comprehensive care plan was not updated to include supplement oxygen therapy. During an interview with the Administrator on 1/13/22 at 3:22 PM, she indicated that Resident # 17 should have had a comprehensive care plan to properly manage his supplemental oxygen therapy. The Administrator was new to the facility and unaware the facility had failed to implement this in Resident # 17's care plan. 2. Resident #62 was admitted to the facility on 8/16/22 with multiple diagnoses that included dementia, lupus erythematosus, protein-calorie malnutrition, and gastro-esophageal reflux disease. The quarterly Minimum Data Set (MDS) dated 11/14/22 revealed Resident #62 was cognitively impaired and had weight loss that was not a prescribed regimen and was on a therapeutic diet. Resident #62's care plan last revised on 11/11/22 revealed no goals or interventions related to Resident #62's nutrition, weight loss or therapeutic diet.	F 656	audit. On 2/8/23, the Facility Consultant and Corporate Clinical Director initiated an in-services with all nurses regarding Care Plans with emphasis on the responsibility of the nurses to include agency and contract to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, and mental/psychosocial needs to include but not limited to resident□s use of oxygen, nutrition, weight loss and therapeutic diet. In-service will be completed by 2/10/23. After 2/10/23, any nurse including agency and contract staff who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired social worker and nurses will be in-serviced during orientation regarding Care Plans. The Director of Nursing/Unit Manager will review 10 resident care plans to include resident #17 and #62 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident□s medical, nursing, dietary needs. The Director of Nursing will address all concerns identified during the audit to include updating care plan when indicated and re-education of the nurse. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all	

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F 656	Continued From page 19 During an interview with the Registered Dietitian on 1/13/23 at 1:22 PM, she indicated she had started working with the facility 4 months ago. She indicated she had not developed or revised any care plans in the facility, and it was the responsibility of the Dietary Manager. An interview was conducted with the Dietary Manager on 1/13/23 at 3:26 pm and she indicated she had not been trained to do care plans and was not sure of who was responsible for during them. On 1/13/23 at 4:04 pm an interview was conducted with the MDS Coordinator, and she indicated the unit managers were responsible for completing and updating the nutrition care plans while the Dietary Manager was being trained. An interview was conducted with Unit Manager on 1/13/23 at 4:09 pm and she indicated she was not responsible for developing the nutrition care plan. The Administrator was interviewed on 1/13/23 at 4:30 pm and she indicated it was expected the care plans be developed. She indicated an audit would be done and they would be assigning someone to do the nutrition care plans.	F 656	concerns were addressed. The Quality Assurance Nurse will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 2/15/23	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		2/15/23

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F 657	Continued From page 20 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and update a care plan and ensure the care plan was signed for 1 of 5 residents reviewed for weight loss. The findings included: Resident #13 was admitted on 6/13/2020 with diagnoses of diabetes mellitus type 2. A review of the medical record revealed an unplanned weight loss as evidenced by monthly weights of 6/6/22 111.4lbs., 7/7/22 109 lbs., 8/11/22 106lbs., 9/6/22 103.5lbs., 10/18/22 104.4lbs., 11/8/22 101.8lbs., 12/20/22 101.6lbs., 1/11/23 95.6lbs.	F 657	F657 Care Plan Timing and Revision On 1/13/23, Resident #13 care plan has been updated for nutrition and weight loss. On 1/18/23 the Registered Dietitian (RD) and Dietary Manager (DM) initiated an audit of all resident care plans to ensure the care plan is updated for nutrition, risk of weight loss. The Registered Dietician and Dietary Manager will address all concerns identified during the audit to include assessment of nutritional needs, weight loss and correct therapeutic diet updating care plan when indicated. The	

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F 657	Continued From page 21 A review of the most recent minimum data set (MDS) dated 11/15/22 revealed resident #13 to be cognitively intact with an unplanned weight loss. A review of the electronic medical record for Resident #13 revealed a comprehensive care plan revised on 12/8/22 and there was no nutrition care plan in place. An interview was conducted with the Registered Dietician on 1/13/23 at 1:20pm. She revealed that she was aware of Resident #13th having poor intake and weight loss concerns and had implemented several interventions which include but are not limited to adding fortified ice cream cups and supplements to his orders. She discussed his current care plan and revealed she was not responsible for the dietary care plans. An interview was conducted with the Dietary Manager on 1/13/23 at 3:25pm. She revealed that she had new to the position and had not yet been trained on the care planning process. An interview was conducted with the MDS coordinator on 1/13/22 at 4:04pm. She reviewed the care plan and was not able to locate a care plan that identified a nutrition focused area. The MDS coordinator's expectation was for weight loss to be care planned and the care plans should be signed after the review is completed. An interview was conducted with the Administrator on 1/13/23 at 4:25 pm. She revealed that it was the dietary's department's responsibility to complete the dietary care plans, but her current dietary manager has not been trained yet on the care planning process.	F 657	audit was completed on 1/18/23. On 2/8/23, the Facility Consultant and Corporate Clinical Director initiated an in-services with all nurses regarding Care Plans with emphasis on the responsibility of the nurses to include agency and contract to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to resident's use of oxygen, nutrition, weight loss and therapeutic diet. In-service will be completed by 2/10/23. After 2/10/23, any nurse including agency and contract staff who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired social worker and nurses will be in-serviced during orientation regarding Care Plans. The Director of Nursing/Unit Manager will review 10 resident care plans to include resident #13 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, dietary needs. The Director of Nursing will address all concerns identified during the audit to include updating care plan when indicated and re-education of the nurse. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns	

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F 657	Continued From page 22	F 657	were addressed. The Director of Nursing will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The Executive QAPI Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 2/15/23	
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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		2/15/23

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F 761	Continued From page 23 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 observations, record review, pharmacy interview, and staff interviews, the facility failed to label inhalers and multidose vials with the date open and date to expire, dispose of expired medications, keep a medication refrigerated per pharmacy instructions, and label inhalers with the minimum required labeling (including a resident's name and instructions for administration) in 1 of 2 medication carts (Hall 300) and 1 of 1 medication rooms observed. The findings included: 1a. Accompanied by Nurse #5, an observation of the Medication Cart used for Hall 300 was conducted on 1/11/23 at 9:21 am. The observation revealed a Wixela (Advair) inhaler labeled with date opened as 11/2/22 and expired on 11/30/22. Nurse #5 stated, "it was probably put in the wrong package, because it was a new inhaler, but I will call the pharmacy to get another one sent out. " An interview with the Pharmacist was conducted on 1/11/22 at 12:13 pm and she indicated the Wixela inhaler was good for 30 days once opened, and if used after the date it can affect the dosage of the medication due to the moisture because it is a powdered medication. 1b. Accompanied by Medication Aide #1, an	F 761	F761 Label/Store Drugs and Biological No Resident was identified for tag F761 On 1/11/23 the Director of Nursing (DON) removed and destroyed all medications that were not labeled with an open date and/or expiration date to include inhaler foil packs, PPD solution, Risperidone Constat-1 injectable, Epogen Solution, Lidocaine HCL, Multi dose Influenza from the 300 hall medication cart per facility protocol. On 1/11/23 an audit of all medication carts and medication rooms to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol and/or returned to the pharmacy timely for destruction, and that all carts were locked when not supervised by assigned nurse. The Director of Nursing will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility protocol, returning expired or discontinued medications to the pharmacy for destruction when indicated and locking	

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F 761	Continued From page 24 observation of the Medication Cart used for Hall 300 was conducted on 1/13/23 at 2:24 pm. The observation revealed an Albuterol HFA inhaler with no date when it was opened or when it was to expire. Medication Aide #1 stated, "It's good for 30 days, I don't know when it was opened." 1c. Accompanied by a Medication Aide #1, an observation of the Medication Cart used for Hall 300 was conducted on 1/13/23 at 2:27 pm. The observation revealed an opened Provir/Ventolin inhaler with a date of 1/25/22 with no date of when it was opened or expired. The pharmacy label stated the inhaler was good for 12 months after opening. Medication Aide #1 stated, "I have never given it, it is as needed." 1d. Accompanied by Medication Aide #1, an observation of the Medication Cart used for Hall 300 was conducted on 1/13/23 at 2:29 pm. The observation revealed an open box of Risperidone Constat-1 injections (antipsychotic medication used treat schizophrenia and symptoms of bipolar disorder) dated as expired on 10/23/22, with instructions on the pharmacy label to keep refrigerated. Medication Aide #1 indicated; she did not give injectable medications. 1e. Accompanied by the Medication Aide #1, an observation of the Medication Cart used for Hall 300 was conducted on 1/13/23 at 2:33 pm. The observation revealed a Spiriva inhaler with a resident's name and room number written on inhaler with black marker. There was no label from the pharmacy with the resident's name or instructions of the medication on the inhaler. The Medication Aide stated, "I put the name and room on it this morning."	F 761	medication cart. The audit will be completed by 1/13/22. On 2/7/23 the Staff Development Coordinator initiated an in-service with all nurses and medication aides regarding Medication Storage with emphasis on labeling medications with an open date/expiration date per facility protocol, responsibility to check medication cart/medication storage room daily for expired medications and discarding expired medications per pharmacy policy. After 2/10/23 any nurse or medication aide to include agency and contract who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses or medication aides to include agency and contract will be in-serviced during orientation regarding Medication Storage. The Night Shift Registered Nurse will audit all medication carts and medication rooms weekly x 4 weeks then monthly x 1 month utilizing the Medication Cart and Medication Room Audit Tool. This audit is to ensure the nurse and/or medication aid labeled medication with an open date/expiration date when indicated, expired medications are removed and destroyed per facility protocol. The Director of Nursing will address all concerns identified during the audit to include labeling mediations with an open date/expiration date when indicated, removing expired medications per facility	

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F 761	Continued From page 25 1f. Accompanied by the Medication Aide #1, an observation of the Medication Cart used for Hall 300 was conducted on 1/13/23 at 2:33 pm. The observation revealed a Wixela (Advair) inhaler with a resident's name and room number written on inhaler with black marker. There was no label from the pharmacy with the resident's name or instructions of the medication on the inhaler. The Medication Aide stated, "I put the name and room on it this morning." On 1/13/23 at 2:38 pm an interview was conducted with the Director of Nursing (DON), and she indicated the inhalers should be dated with the open and expiration dates and should be in the package they came from the pharmacy in with the resident's name and instructions from the pharmacy. The DON indicated any medications that require refrigeration should be refrigerated. She stated the 3rd shift nurses were supposed to be checking the medication carts on their shifts but obviously they were not. An interview was conducted with the Administrator on 1/13/23 at 4:32 pm and she indicated the inhalers should be dated when opened and when they expired. 2. On 1/12/23 at 2:17 PM an observation was conducted of the central medication room. The observation revealed several multi dose vials were opened and not labeled with an open date. The medications included: - An Epogen Solution (medication used to treat anemia in people with long term serious kidney disease)20000 UNIT/ML vial (Epoetin Alfa) with an ordered date of 11/30/2022 and discontinued date of 1/5/2023	F 761	protocol. The Director of Nursing (DON) will review Medication Cart and Medication Room Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. for completion and to ensure all areas of concerns were addressed. The Director of Nursing will present the findings of the Medication Cart and Medication Room Audit Tool the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Medication Cart and Medication Room Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 2/15/23	

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F 761	Continued From page 26 - Lidocaine HCL (medication used to numb patients having certain medical procedures)1% 200 milligram/ 20 milliliter multi dose vial (lot # GK2723). - Three multi dose Tuberculin solution (medication used in a skin test to aid diagnosis of tuberculosis infection) vials. - Multi dose Influenza vaccine vial. The Center for Disease Control (CDC) Injection Safety practices recommends if a multi-dose vial has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. An interview on 1/12/23 at 2:38 PM was conducted with the DON, and she indicated she was unaware of any medications or vials opened without a labeled date to indicate when they were opened. She reported she expected the medications to be labeled with an open date when the nurse initially used it. She stated the 3rd shift nurses were supposed to be checking the medication room refrigerators on their shifts but obviously they were not. She indicated the Epogen solution vial had been discontinued and should have been removed from the refrigerator.	F 761		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		2/15/23

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F 804	Continued From page 27 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to serve food that was palatable for 10 of 10 residents (Resident #9, Resident #11, Resident #13, Resident #18, Resident #19, Resident #24, Resident #34, Resident #44, Resident #59, and Resident #64) that were reviewed for food palatability. Findings Included: Resident council meeting was conducted on 1/11/23 at 11:30am. Resident #24, Resident #19, Resident # 64, and Resident #44 were in attendance and revealed that they had voiced complaints regarding cold food and food not tasting good in previous resident council meetings. The residents further revealed that their complaints had not been resolved. An observation was made of the steam table in the kitchen on 1/12/23 at 11:45am. The lunch meal was on the steam table. The food was placed in Styrofoam containers with lid and placed on a closed stainless still food delivery cart at 12:05pm. This food delivery cart also included a test tray that was prepared at 12:05pm, from the kitchen steam table and contained sloppy joe beef and sauce on bun, tater tots, and carrots. The test tray was delivered to the 100 Hall at	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp On 1/11/23, Residents #9, #11, #13, #18, #19, #24, #34, #44, #59, #64 the Dietary Manager offered the residents a new tray for lunch. If the resident refused an alternative was offered. On 1/12/23 and 1/13/23 the Dietary Manager audited a test tray coming out of the Kitchen to the 100 hall with no negative findings. On 2/7/23 The Corporate Certified Dietary Manager in-serviced the Dietary Manager for the facility on Nutritive Value/Appear, Palatable/Prefer Temp. The Dietary Manager will interview 15 residents on weight loss, correct diet, snacks, preferences, assistive devices using the Resident Questionnaire 1 time a week, X 4 weeks. The Dietary Manager will audit a test tray to 100, 200, 300 and 400 Halls, randomly 3 times weekly x 4 weeks. The test tray audit tool will be given to the Administrator for review. The Administrator will present the findings of the Test Tray Audit Tool to the Quality	

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F 804	Continued From page 28 12:08pm with the lunch trays for all the residents on the 100-hall. Staff began to deliver trays at 12:09pm. At 12:38pm there were three trays left for residents who required feeding assistance. The food items were tasted by the DM and the surveyor at 12:39pm. The tater tots were cold, the carrots were warm, and the sloppy joe beef was not seasoned and cold. The DM agreed the food items were all cold. An observation and interview conducted on 1/12/23 at 12:25pm revealed Resident #9's lunch meal of grilled pimento cheese sandwich Resident stated her grilled pimento cheese sandwich was burnt and received burnt food and cold food regularly. During an interview with Resident # 13 on 1/12/23 12:21pm observed resident not eating lunch and indicated that the facility food does not taste good and was cold. During an interview with Resident #34 on 1/12/23 12:24pm she revealed that she did not like the taste of her food today because it was burnt and cold and she had already sent her tray back. She further revealed that she has received burnt and cold food several times before and just sends it back to the kitchen. During an interview with Resident # 11 on 1/12/23 at 12:25pm observed a tray of food which contained grilled cheese sandwich uneaten. Resident # 11 indicated that she did not think that food looked like it would taste good and so she declined the meal. She further revealed that she often does not like the taste of the food and it is often served cold so she sends it back to the kitchen.	F 804	Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Test Tray Audit Tool determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 2/15/23	

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F 804	Continued From page 29	F 804		

An interview was conducted with Resident # 59 on 1/12/23 at 12:33pm. She revealed that she had received a burnt grilled pimento cheese sandwich and did not like it how it was made, so she sent it back. She further revealed that she has received burnt and cold food many times before and just sends it back to the kitchen. During an interview with the family member of Resident # 18 on 1/12/23 at 12:29pm he revealed that he comes into the facility often to eat with his wife and finds that the food is cold often and must ask staff to heat up her food. Observation of meal tray revealed grilled pimento cheese sandwich that was burnt, and family member stated it was cold to the touch.

Resident #19 was interviewed on 1/ 12 /23 at 3:30pm and stated the food was cold daily and that was why she ordered out so much.

Resident #64 was interviewed on 1/12/23 at 11:30am reported indicated the food was cold daily and that was why she ordered out.

Resident #44 was interviewed on 1/ 12/23 7:25pm at am and indicated "that snacks and food here are problems, been that way for a long time." "People just do not care anymore so you get tired of complaining and take it as it comes."

During an interview with the DM on 1/12/23 at 12:38pm she revealed that she had only been in this position for 3 weeks and not aware of any specific resident food complaints but that if a resident requested something else to eat, she makes sure they get something else. It was her expectation that food was served timely, and tasted good to the residents.

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F 804	Continued From page 30 An interview was conducted with the Corporate Dietary Manager on 1/9/23 12:35 pm. He reported that the facility was using Styrofoam due to a broken dishwasher. The service contractor was contacted on 1/6/23. An interview was conducted with the Administrator on 1/11/23 at 9:21am. She stated that the service contractor was onsite on 1/10/23 to repair the dishwasher and parts are now on order. An interview was conducted with the Administrator on 1/13/23 at 4:27pm. She has only been in this position since last month and revealed that her expectation was that the food was palatable.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with	F 809		3/6/23

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F 809	Continued From page 31 the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews the facility failed to provide snacks to residents. Seven out of 10 Residents (Resident #74, Resident #24, Resident #19, Resident #64, Resident #59, Resident # 10, and Resident #44) who attended Resident Council meeting, stated they were not offered snacks daily. The facility failed to serve dinner meals on time, as indicated on the mealtime schedule for all residents who received food from the kitchen, observed on the 400 hall. The findings included: 1. During a resident council meeting that was held on 1/11/23 at 11:30 am when the question was asked, do you receive snacks at bedtime or when you request them, residents responded as follow: Resident #74 answered, "No, not at all." Resident #74 was admitted to the facility on 3/29/22. A review of the most recent quarterly review Minimum Data Set dated in 2022 indicated that resident was cognitively intact. " Resident #24 indicated snacks were not given or offered during the entire day. Resident #24 was admitted to the facility on 09/23/21 and most recent quarterly review Minimum Data Set dated 12/22/22 identified the resident as cognitively intact. " Resident #19 stated snacks were not offered and when requested nothing was available. Resident stated there were no snacks. Resident	F 809	F809 Frequency of Meals/Snacks at Bedtime On 1/11/23, The Dietary Manager provided a snack to Residents #74, #24, #19, #64, #59, #10, #44. On 1/11/23, The Dietary Manager increased the number and amount of snacks to be delivered on the snack delivery times of 10 am, 2 pm and 7pm. All residents will be offered snacks at 10 am, 2 pm and 7pm. Snacks will be placed in the nourishment room daily for residents to have access to them upon their request. On 2/7/23 The Corporate Certified Dietary Manager in-serviced the Dietary Manager for the facility on Frequency of Meals/Snacks at Bedtime and all residents will be offered snacks throughout the day and evening by the nursing staff. The Dietary Manager will interview 15 residents on snacks, to include Did you receive a snack today? Did you request a snack, if not what happened? Are you being provided a snack at bedtime and/or did you request a snack at bedtime? If requested and not provided, please describe, and food preferences for meals and snacks, using the Resident Questionnaire 1 time a week, X 4 weeks. The Director of Nursing/Administrator will	

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F 809	Continued From page 32 #19 was admitted to the facility on 3/12/21. Resident #19's most recent quarterly Minimum Data Set dated in 2022 indicated that she was cognitively intact. A second interview was conducted with Resident #19 on 1/13/23 at 10:50 AM, Resident #19 confirmed that snacks were not given on the 300 hall the previous night. " Resident #64 indicated that no kitchen staff or nursing staff passed out snacks. Resident #64 stated that snacks were not offered. Resident #64 was admitted to the facility on 4/20/22 and her most recent quarterly Minimum Data Set dated November 2022 identified the resident as cognitively intact. " Resident #59 stated snacks were not provided during the day or night. Resident #59 who was admitted to the facility on 3/12/20 and who most recent quarterly Minimum Data Set dated 01/03/2022 identified the resident as cognitively intact. A second interview was conducted with Resident #59 on 01/13/23 at 10:10 AM. Resident #59 indicated she did not receive a snack last night. " Resident #10 indicated she agreed with Resident#59. Resident #10 who was admitted to the facility on 12/21/21 and her most recent quarterly Minimum Data Set dated 12/2022 identified the resident as cognitively intact. " Resident #44 indicated that the snacks were never offered and or passed out on his hall. Resident #44 who was admitted to the facility on 10/12/19 and who most recent quarterly review Minimum Data Set dated 12/2022 identified the resident as cognitively intact. A second interview was conducted with Resident #44 on 01/13/23 at	F 809	review the Resident Questionnaire Advance Directive Audit Tool 1 times a week x 4 weeks then monthly x 2 month to ensure all concerns were addressed. The Dietary Manager will audit a test tray to 100, 200, 300 and 400 Halls, randomly 3 times weekly x 4 weeks. The test tray audit tool will be given to the Administrator for review. The Director of Nursing/Administrator will present the findings of the Resident Questionnaire and Test Tray Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Test Tray Audit Tool determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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10:25 am. Resident #44 indicated he did not receive snack the previous night.

Resident #14, Resident #7, and Resident #5 were also present during the resident council meeting and were observed to be nodding their heads in agreement with the other residents.

The Resident Council President was interviewed during this Resident Council Meeting. The Resident Council President stated that there were always problems snacks.

The nutrition room observations for all 4 halls were conducted on 1/12/23 at 4:30 PM and at 7:10 PM. Observation revealed juices in the refrigerator and 2 packs of 4 "gelatin cups" observed on the countertop.

Interview was conducted with the Dietary Manager on 1/12/23 at 7:15PM, who indicated that snacks were provided daily to all residents who wanted and/ or needed a snack. She indicated that the kitchen staff provided snacks to all halls at 7AM, 2 PM and 7 PM. Surveyor informed Resident Council President the Dietary Manager during this interview that observations were made, and juices and jell-o were only observed.

2. During an observation on 1/12/23 at 7:15 PM, the dinner cart was observed coming on the 400 hall.

During an interview on 01/12/22 at 7:20 PM, Resident #24, stated that the food on the hall (400 hall) was always last and this happened at least 4 or 5 times a week. Resident #24 indicated the residents never knew why the meals were

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served late.

A dinner tray was observed delivered to Resident #44 on 1/12/22 at 7:25 PM. Resident #44 stated the meals were served to the hall as late as 8:00 PM. Resident #44 further stated that the residents did complain about the meals being late, but no action was taken. Resident #44 indicated he was now used to dinner meals coming between 7:00 and 8:00 nightly.

An interview was conducted with Resident #67 on 1/12/22 at 7:30 PM who indicated, that as always, dinner was late again. Resident #67 was not observed eating his dinner. Resident #67 indicated that it was something he did not want. Resident #67 stated the dinner meals were late weekly, and the residents were just use to it now.

Interview was conducted with Nursing Assisted (NA) #4, on 1/12/22 at 7:40 PM. NA indicated that she worked night shifts and on 400 and 300 halls. NA #4 indicated she does not give out snack on the halls because the dinner meal usually was served late. Staff and residents were not provided any explanation as to why the meals were out late. NA #4 indicated that there are juices in the refrigerator, unsure about sandwiches and most of the time snacks were not offered. NA #4 stated she did not recall passing out snacks when dinner meal was not late. NA #4 further stated snacks were not available to be offered to the residents.

During an interview on 01/13/23 at 3:30 PM, the Dietary Manager indicated dinner meals on 1/12/23 on the 400 hall was served late due to a problem in the kitchen. The Dietary Manager indicated that it was her expectation that

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F 809	Continued From page 35 residents were served their meals on scheduled mealtimes. The Dietary Manager further stated that the Dietary staff would communicate with the Nursing staff if meals were going to be late and assure that the residents had something to snack on during the wait time. During an interview with Director of Nursing and Administrator on 01/13/23 at 4:15 PM both indicated their expectation for the dietary staff and cook to communicate any issues or concerns to Nursing staff about meals being late and for the expectation of kitchen staff to provide snacks to each hall for the scheduled snack time and that all residents are provided and offered snacks daily. The Administrator also indicated that she expected all meals served timely.	F 809		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to place food in individual bowls to differentiate between food items and to access each item easily for 1 of 1 residents reviewed for accommodation of needs (Resident #13). Findings included: Resident #13 was admitted on 6/13/2020 with	F 810	F810 Assistive Devices-Eating Equipment/Utensils On 1/11/23 the Resident #13, Styrofoam container was taken back to the kitchen and the food with regular texture, double portions were placed in bowls. The Dietary Manager began serving residents care planned for food in bowls.	2/15/23

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F 810	Continued From page 36 diagnoses of legal blindness. A review of the most recent minimum data set (MDS) dated 11/15/22 revealed resident #13 to be cognitively intact and have severely impaired vision. During an observation on 1/9/23 at 12:30pm meal trays were delivered to the residents in Styrofoam containers, bowls, and cups. An interview was conducted on 1/9/23 at 12:35pm with the Corporate Dietary Manager. He revealed that the facility dishwasher stopped working on 1/6/23 and meals were being served in styrofaoam containers, bowls, and cups and are utilizing disposable cutlery until the dishwasher is fixed. Resident #13 was observed and interviewed on 1/11/23 at 12:26pm. The observation revealed Resident #13 sitting on the side of bed in front of his lunch tray with food in one single styrofoam container. The diet ticket on meal tray for Resident #13 indicated "all food in bowls". Resident #13 indicated that he could not see to tell the difference between the different food items and did not eat his meal. Another observation occurred with Resident #13 on 1/13/23 at 12:21pm. The observation revealed that Resident #13 received lunch meal in one single styrofoam container and refused to eat his food. A review of the Registered Dietician progress note dated 11/22/22 revealed a diet order for regular texture, double portions all food in bowls. An interview was conducted with the Registered Dietician on 1/13/23 at 1:20pm. She revealed that the current diet order was for regular texture,	F 810	The bowls were to return to the kitchen and be washed in the 3-sink method□wash, rinse, sanitize. Styrofoam containers were no longer used for the residents requiring food in bowls. The dishwasher was down and not functioning, the facility had to switch to Styrofoam for all meals per the Guilford County Health Department until the dishwasher was fixed on 1/18/23. The Dietary will interview 15 residents on adaptive equipment using the Resident Questionnaire 1 time a week, X 4 weeks. Resident Questionnaire 1 time a week, X 4 weeks. The Dietary Manager will audit adaptive equipment on 100, 200, 300 and 400 Halls, randomly 3 times weekly x 4 weeks. The test tray audit tool will be given to the Administrator for review. The Administrator will present the findings of the Test Tray Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Test Tray Audit Tool determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. Date of Alleged Compliance 2/15/23	

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F 810	Continued From page 37 double portions and all food in bowls. She indicated that by providing the food in bowls helps this resident to differentiate between the food items and to make it easier for Resident #13 to scoop food onto the fork or spoon.	F 810		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey dated 4/12/21. This was discovered for one deficiency cited in the areas of develop/implement care plan. A care plan implementation deficiency was cited again on the recertification and complaint survey dated 1/13/23. The repeated citation during the two surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F 656: Based on observation, record review and staff interviews, the facility failed to develop and implement a comprehensive care plan with	F 867	F867 QAPI/QAA Improvement Activities On 1/18/23 The Registered Dietitian and Dietary Manager updated the care plan for #62 for nutrition, weight loss, therapeutic. On 2/6/23 The MDS nurse and the Dietary Manager updated the care plan for resident #17 for oxygen. On 2/8/23, a 100% audit of all resident care plans begun and will be completed by 2/15/23. The audit will review care plans to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to resident's use of oxygen, nutrition, weight loss and therapeutic diet. On 2/8/23, the Facility Consultant and Corporate Clinical Director initiated an	2/15/23

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F 867	Continued From page 38 measurable objectives and interventions in the areas of oxygen therapy and nutrition for 2 of 7 sampled residents. (Resident # 17 and # 62). During the recertification and complaint survey dated 4/12/21 the facility failed to develop an individualized and person-centered care plan that addressed Resident discharge for 1 of 2 residents (Resident #126) reviewed for discharged. An interview with the Administrator was conducted on 01/13/23 at 4:35 pm. She indicated her expectation was for the team to work together to maintain an effective Quality Assurance Performance Improvement Committee to ensure the facility does not repeat a previous deficient practice.	F 867	in-services with all nurses regarding Care Plans with emphasis on the responsibility of the nurses to include agency and contract to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to resident's use of oxygen, nutrition, weight loss and therapeutic diet. In-service will be completed by 2/10/23. After 2/10/23, any nurse including agency and contract staff who has not completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired social worker and nurses will be in-serviced during orientation regarding Care Plans. On 2/7/23, the Corporate Clinical Director initiated an in-service for the Quality Assurance Performance Improvement (QAPI) Committee on the process of the QAPI The Director of Nursing/Unit Manager will review 10 resident care plans to include resident #13 weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, dietary needs. The Director of Nursing will address all concerns identified during the audit to include updating care plan when indicated and re-education of the nurse. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then	

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F 867	Continued From page 39	F 867	monthly x 1 month to ensure all concerns were addressed. The Director of Nursing/Unit Manager will review 10 resident care plans weekly x 4 weeks then monthly x 1 month utilizing the Care Plan Audit Tool. This audit is to ensure resident care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, dietary needs. The Director of Nursing will address all concerns identified during the audit to include updating care plan when indicated and re-education of the nurse. The Director of Nursing will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Facility Consultant/Corporate Clinical Director will attend the facility Quality Assurance Performance Improvement (QAPI) monthly meetings, to ensure the facility is following the Regulatory and Corporate Policy for QAPI. The Facility Consultant/Corporate Clinical Director will review the minutes, and the Performance Improvement Plans once a month for 3 months. The Director of Nursing will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the Care Plan Audit Tool to determine trends	

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F 867	Continued From page 40	F 867	and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. The Administrator will hold monthly Quality Assurance Performance Improvement Committee (QAPI) meetings with the QAPI committee to include the Medical Director, Pharmacist, Administrator, Director of Nursing, Social Worker, Dietary Manager, Therapy Director, MDS Coordinator, Unit Managers. Meeting Agenda will include review of all Performance Improvement Plans (PIP) to include the PIP for Care Plan Timing/Revision and Develop/Implement Comprehensive Care Plan. The Care Plan Audit Tool will be reviewed monthly to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Date of Alleged Compliance 2/15/23	