STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345207	A. BUILDING _____ B. WING _____	C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET WHITEVILLE, NC 28472

(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 was conducted on 05/01/23 through 05/04/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # UCNB11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted from 05/01/23 through 05/04/23. Event ID # UCNB11. The following intakes were investigated: NC00195025, NC00195504, NC00195298, and NC00200634. 1 of the 12 complaint allegations resulted in deficiency.	F 000		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		5/24/23

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

Electronically Signed | 05/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 636	Continued From page 1 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

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F 636	Continued From page 2 Based on record review and staff interview the facility failed to complete comprehensive assessments within the 14-day required timeframe for 7 of 19 residents (Resident #82, Resident #32, Resident #75, Resident #81, Resident #71, Resident #28 and Resident #37) reviewed for comprehensive Minimum Data Set (MDS) assessments. Findings included: 1. Resident #82 was admitted to the facility on 3/1/23. Resident #82's admission MDS dated 3/7/23 was completed on 3/27/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 2. Resident #32 was admitted to the facility on 2/10/23. Resident #32's admission assessment dated 2/17/23 was completed on 3/2/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware	F 636	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. F636 – Comprehensive Assessment and Timing Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required 14 day timeframe was completed as follows: • Resident #82 was admitted to the facility on 3/1/2023. Admission Minimum data set assessment with Assessment Reference Date of 3/7/2023 was completed on 3/27/2023. • Resident #32 was admitted to the facility on 2/10/2023. Admission Minimum data set assessment with Assessment Reference Date of 2/17/2023 was completed on 3/2/2023. • Resident #75 was admitted to the facility on 12/7/2021. Annual Minimum data set assessment with Assessment Reference Date of 12/15/2022 was completed on 1/2/2023. • Resident #81 was admitted to the facility on 12/30/2022. Admission	

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F 636	Continued From page 3 of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 3. Resident #75 was admitted to the facility on 12/7/21. Resident #75's annual MDS assessment dated 12/15/22 was completed on 1/2/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 4. Resident #81 was originally admitted to the	F 636	Minimum data set assessment with Assessment Reference Date of 1/6/2023 was completed on 1/30/2023. • Resident #71 was admitted to the facility on 10/22/2021. Annual Minimum data set assessment with Assessment Reference Date of 11/2/2022 was completed on 11/23/2022. • Resident #28 was admitted to the facility on 11/14/2022. Admission Minimum data set assessment with Assessment Reference Date of 11/21/2022 was completed on 12/28/2022. • Resident #37 was admitted to the facility on 2/1/2023. Admission Minimum data set assessment with Assessment Reference Date of 2/8/2023 was completed on 3/2/2023. 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. A 100 % review of all current residents with a comprehensive assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14 days timeframes. This audit will be completed by the regional Minimum data set consultant no later than 5/24/2023 • Effective 5/24/2023, the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the	

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F 636	Continued From page 4 facility on 12/30/22. Resident #81's admission MDS assessment dated 1/6/23 was completed on 1/30/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 5. Resident #71 was admitted to the facility on 10/22/21. Resident #71's annual MDS assessment dated 11/2/22 was completed on 11/23/22. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The	F 636	interdisciplinary team members of the residents with assessment reference dates (ARD) for that date as well as any residents with in progress assessments that are due for completion (Minimum data set assessment Z0500 date) on that date. This has been added to the daily stand up meeting process. • Regional Minimum data set consultant will audit the current Minimum data set assessments in progress list for comprehensive assessments that are due to be completed (Minimum data set item Z0500 due date of 5/24/2023) by May 24, 2023. Facility Minimum data set coordinator with assistance of Minimum data set assessment floater will complete the identified assessments (in progress comprehensive assessments with Z0500 due date of 5/24/23 or earlier) by May 24, 2023 Systemic Changes By 5/24/2023, the Regional MDS consultant will complete an in-service training with the facility Minimum Data Set Coordinator that includes the importance of ensuring that each resident receive a comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory	

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F 636	Continued From page 5 Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 6. Resident # 28 was admitted to the facility on 11/14/22. Resident #28's admission MDS assessment dated 11/21/22 was completed on 12/28/22. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 7. Resident #37 was admitted to the facility on 2/1/23. Resident #37's admission MDS assessment dated 2/8/23 was completed on 3/2/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left	F 636	requirements. The Director of Nursing or designee will begin auditing the facility's compliance with comprehensive Minimum Data Set assessments completion time frames as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled "Comprehensive Assessments and Timing Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be completed on 5 residents' completed assessments per audit and will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 5/24/23	

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F 636	Continued From page 6 several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse.	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly assessments within the required 14-day timeframe for 5 of 19 residents reviewed for Minimum Data Set (MDS) assessments (Resident #45, Resident #59, Resident #41, Resident #62, and Resident #60). Findings included: 1. Resident #45's quarterly Minimum Data Set (MDS) dated 3/30/23 was completed on 4/20/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments	F 638	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. F638 Quarterly Assessment at Least Every 3 Months	5/24/23

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F 638	Continued From page 7 and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 2. Resident #59's quarterly MDS assessment dated 3/31/23 was completed on 4/20/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 3. Resident #41's quarterly MDS dated 1/27/23 was completed on 2/13/23. An interview on 5/4/23 at 1:49 PM with the MDS	F 638	Corrective Action Minimum Data Set assessment for affected residents that were identified as not being completed within the required 14-day timeframe was completed and submitted to the state database as follows: • Resident #45: Quarterly Minimum data set assessment with Assessment Reference Date of 3/30/2023was completed on 4/20/2023 • Resident #59: Quarterly Minimum data set assessment with Assessment Reference Date of 3/31/2023 was completed on 4/20/2023 • Resident #41: Quarterly Minimum data set assessment with Assessment Reference Date of 1/27/2023 was completed on 2/13/2023 • Resident #62: Quarterly Minimum data set assessment with Assessment Reference Date of 3/31/2023 was completed on 4/20/2023 • Resident #60: Quarterly Minimum data set assessment with Assessment Reference Date of 4/10/2023 was completed on 5/1/2023 Identification of other residents who have the potential to be affected by this alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a quarterly assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14-day completion timeframes. This audit	

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F 638	Continued From page 8 Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 4. Resident #62's quarterly MDS assessment dated 3/31/23 was completed on 4/20/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse. 5. Resident # 60 's quarterly MDS dated 4/10/23	F 638	will be completed by the regional Minimum data set consultant no later than 5/24/2023 • Effective 5/24/2023, the facility Minimum data set Nurse will review the Minimum data set in progress list in PCC Software daily (Monday through Friday) and inform the IDT members of the residents with ARDS for that date as well as any residents with in progress assessments that are due for completion (MDS Z0500 date) on that date. This has been added to the daily stand up meeting process. • Regional Minimum data set consultant will audit the current Minimum data set assessment in progress list for quarterly assessments that are due to be completed (item Z0500 due date of 5/24/2023) by May 24, 2023. Facility Minimum data set coordinator with assistance of Minimum data set floater will complete the identified assessments (in progress quarterly assessments with Z0500 due date of 5/24/23 or earlier) by May 24, 2023 By 5/24/2023 the regional minimum data set consultant will conduct education/training with the facility Minimum Data Set Nurse on the importance of scheduling and completing a Minimum Data Set assessment for all residents at least once every 3 months per chapter 2 of the Resident Assessment Instrument manual. The education will emphasize that all residents must have no more than 92 days between Assessment	

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F 638	Continued From page 9 was completed on 5/1/23. An interview on 5/4/23 at 1:49 PM with the MDS Nurse revealed she had been in the position since November 2022. She stated she was aware of the time frames for completion of assessments and explained when the previous MDS Nurse left several months ago, assessments remained incomplete and late. The MDS Nurse stated she was trying to catch up while learning the position. An interview with the Administrator on 5/4/23 at 2:41 PM revealed the current MDS Nurse was new to the position and to the MDS process. The Administrator stated she was aware of the situation with MDS assessments not completed within the regulatory timeframe and the corporate MDS Nurse was coming to assist the new MDS Nurse.	F 638	Reference Dates of each Minimum Data Set assessment (Admission, Annual, Quarterly, Significant Change). Focus will be placed on the importance of ensuring that all Minimum Data Set assessments be completed in the required time frames, as well as encoded and transmitted within the required timeframes as set forth by CMS as stated in Chapter 2 of the Resident Assessment Instrument Manual. Monitoring The monitoring procedure to ensure that the plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance within the regulatory requirements; The Director of Nursing and/or designee will review 5 random residents who have recently completed Quarterly MDS assessment to validate whether or not most recent Minimum data set quarterly assessment was completed (Z0500 date) within the 14 day required timeframe (date of Z0500 assessment completion date). This will be completed using the Quality Assurance tool entitled “Quarterly Completion of Minimum Data Set Assessments” Audit tool. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit	

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F 638	Continued From page 10	F 638	Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 5/24/2023	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, and observation the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of 1.) bed rails (Resident #59); 2). vision and hearing (Resident #41) and 3). tobacco use (Resident #60) for 3 of 19 residents reviewed for accuracy of MDS assessments. The findings included: 1.) Resident #59 was admitted to the facility on 06/21/2019. Review of the quarterly MDS assessment dated 03/31/2023 revealed Resident #59 was severely cognitively impaired and was totally dependent on staff for activities of daily living (ADL) care. The assessment for side rail use was coded no. An interview was conducted with the Nurse Consultant and the Administrator on 05/03/2023	F 641	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. F-641 Accuracy of Assessments Corrective actions Resident #59 Minimum data set quarterly assessment with Assessment Reference date of 3/31/2023 reviewed and resident does not have side rails coded on the MDS. Updated side rail assessment was completed on resident	5/24/23

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F 641	Continued From page 11 at 11:17 A.M. The Nurse Consultant stated the facility had decided to change Resident #59's bed to a bariatric bed with half rails after a fall in July 2022. An interview was completed with the MDS Nurse on 05/04/2023 at 12:21 P.M. The MDS Nurse stated that she was unaware that bed rails were supposed to be coded on the MDS assessment. An interview was conducted with the Director of Nursing (DON) on 05/04/2023 at 3:52 P.M. The DON stated that the MDS Nurse was new and still learning the process. She further stated that the MDS was supposed to be coded accurately and the side rails should have been coded as yes for being used by the resident. 2. Resident #41 was admitted to the facility on 9/16/22 with diagnoses which included in part: cognitive communication deficit, cerebrovascular accident, and dementia. Review of Resident #41's medical record revealed an evaluation by a hearing instrument specialist on 1/12/23 which indicated moderate to severe hearing loss in both ears. The resident had over the counter hearing aids and a recommendation was made for new hearing aids. Resident #41's quarterly MDS assessment dated 1/27/23 indicated the resident was alert, oriented, and had adequate hearing with no hearing aids. An interview was conducted on 5/4/23 at 12:52 PM with Resident #41. She indicated she had hearing loss and wore bilateral hearing aids. Resident #41 stated she did not wear them all the time because staff didn't help her. Resident #41	F 641	and per staff completing assessment the rail usage is not a restraint for this resident Resident #41 Minimum data set assessment with Assessment reference date of 1/27/2023 was modified and corrected by the facility Minimum data set Nurse on 5/22/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment. Resident #60 Minimum data set assessment with Assessment reference date of 1/10/2023 was modified and corrected by the regional minimum data set consultant on 5/22/2023 and the resident's tobacco use status in Section J was corrected to reflect resident's current tobacco use during the Assessment reference date lookback timeframe. 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. A 100 % audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents who use tobacco, use hearing aids/sound amplifiers, and those that have side rails/grab bars that meet the definition of restraint will be completed in order to identify if the following questions were coded accurately in the section of B0200, B0300, J1300, P0100A on the Minimum data set assessment: • B0300 – Hearing aid • J1300 – Tobacco use • P0100A – Bed Rail	

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F 641	Continued From page 12 stated she required assistance to put in and maintain her hearing aids. Hearing aids were observed on Resident #41's bedside table. A sign was posted her room regarding applying and maintaining the hearing aids. An interview on 5/4/23 at 1:43 PM with Med Aide #2 revealed that Resident #41 had trouble with hearing and required bilateral hearing aids. Med Aide #2 stated that sometimes the resident wore the hearing aids and sometimes she didn't. An interview with the MDS Nurse on 5/4/23 at 1:54 PM revealed that she was new to the MDS process. The MDS Nurse stated that hearing loss and hearing aids should be coded on the MDS. An interview on 5/4/23 at 3:21 PM with NA #5 revealed Resident #41 sometimes wore hearing aids and sometimes she didn't. NA#5 further indicated hearing aids and hearing loss weren't on Resident #41's care guide but should be. An interview on 5/4/23 at 3:38 PM with the Administrator revealed that MDS assessments should be accurate and reflect the needs of the residents. 3. Resident #60 was admitted to the facility on 6/10/19 with diagnoses which included in part: cerebrovascular accident and nicotine dependence. Review of Resident #60's care plan initiated on 3/14/22 revealed a problem of at risk for injuries related to preference to smoke with a goal of risk for smoking related injuries will be minimized through current interventions through the next 90	F 641	This audit will be completed by regional Minimum data set consultant no later than 05/24/2023. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator. Any necessary Minimum data set corrections will be completed no later than 05/24/2023 Systemic Changes By 5/24/2023, the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse that includes the importance of thoroughly reviewing each resident's medical record in order ensure that the assessment is coded accurately. Special emphasis will be placed on the following areas of the Minimum Data Set assessment: B0200 Hearing- Based on the information reviewed, the Minimum data set nurse should interview and assess the resident's hearing function as well as assess whether the resident uses hearing aids. If possible, this assessment should be done directly with the resident. If unable to assess the resident, then the direct care staff members should be interviewed and the medical record thoroughly reviewed to determine accurate status of hearing and vision in order to be able to accurately code Section B for Hearing, Hearing Aid. The assessor should then code Section B0200 to accurately reflect resident's status during the Assessment reference	

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F 641	Continued From page 13	F 641		

days. Interventions included: make sure resident wears clothing that is appropriate for current weather conditions, instruct resident to smoke only in designated areas, provide resident with smoking items upon request, report to the nurse and Social Worker if resident refused to follow safe smoking interventions.

Review of Resident #60's medical record revealed a 9/14/22 smoking assessment which indicated the resident was able to smoke independently.

Resident #60's annual MDS assessment dated 1/10/23 indicated the resident was alert, oriented, and current tobacco use was coded as no.

An interview with Resident #60 on 5/02/23 at 1:06 PM revealed she was a smoker. Resident #60 stated she handled her own smoking materials. Resident #60 stated she had a locked drawer in her room where she kept her smoking materials, she went outside to smoke any time she wanted and was aware of where the smoking area was.

An interview with the MDS Nurse on 5/4/23 at 1:53 PM indicated she was new to the MDS process. The MDS Nurse indicated tobacco use should be listed in Resident #60's assessment.

An interview with the Administrator on 5/4/23 at 3:39 PM revealed that assessments were to be accurate and reflect the needs of the residents.

date lookback time frame.
J1300 Tobacco Use - The Minimum data set nurse should interview and assess the resident's use of tobacco. If possible, this assessment should be done directly with the resident. If the resident is unable to answer or indicates that he or she did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period.
P0100A Bed Rail- The Minimum data set nurse should assess the residents use of bed rails to determine if bed rails are in use during the look back period and if the bed rail/rails meets the definition of a physical restraint. Bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
— Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A.
— Bed rails used with residents who are immobile. If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint

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F 641	Continued From page 14	F 641	The MDS needs to be thoroughly reviewed for accuracy prior to closing and locking the assessment. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments with Assessment reference date of 5/8/2023 or later for accuracy in coding on the Minimum data set assessment for hearing aids (B0200), use of tobacco products (J1300), and any side rails that meet the definition of restraint(P0100) to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be done weekly x 4 weeks and then monthly x 2 months using the audit tool titled “Accurate Coding of MDS Audit Tool”. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director.	

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F 641	Continued From page 15	F 641	The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 5/24/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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.	F 656		5/24/23

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F 656	Continued From page 16 (B) The resident's preference and potential for 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive person-centered care plan in the areas of 1.) bed rails (Resident #59) and 2.) hearing loss (Resident #41) for 2 of 19 residents reviewed for comprehensive care plans. Findings included: 1. Resident #59 was admitted to the facility on 06/21/2019. Review of the quarterly Minimum Data Set (MDS) assessment dated 03/31/2023 revealed Resident #59 was severely cognitively impaired and totally dependent on staff for activities of daily living (ADL) care. The assessment for bed rail use was coded no. Review of Resident #59's care plan last reviewed on 01/31/2023 did not include the use of bed rails to prevent falls.	F 656	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. F656 Develop/Implement Comprehensive Care Plan Corrective action Resident #59: Review of resident's care plan last reviewed on 1/31/2023 did not include current bed rail usage. Care plan has been reviewed and revised on 5/19/2023 by facility Minimum data set nurse. Resident has a comprehensive	

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F 656	Continued From page 17 An interview with the Nurse Consultant occurred on 05/03/2023 at 11:17 A.M. The Nurse Consultant stated the facility had implemented the use of bed rails in July 2022 to prevent her from falling out of bed. An interview with the MDS Nurse was completed on 05/04/2023 at 12:21 P.M. The MDS Nurse stated that she did not know that bed rails were supposed to be included in the care plan. An interview with the Administrator occurred on 05/04/2023 at 12:43 P.M. The Administrator stated that the MDS Nurse was new and inexperienced and may not have realized that the use of bed rails needed to be reflected in the care plan. 2. Resident #41 was admitted to the facility on 9/16/22 with diagnoses which included in part: cognitive communication deficit, cerebrovascular accident, and dementia. Review of Resident #41's care plan dated 1/10/23 revealed communication problem with hearing deficit and use of hearing aids was not included. Resident #41's quarterly MDS assessment dated 1/27/23 indicated the resident was cognitively intact and had adequate hearing with no hearing aids. An interview was conducted on 5/4/23 at 12:52 PM with Resident #41. She indicated she had hearing loss and wore bilateral hearing aids. Resident #41 stated she did not wear them all the time because staff didn't help her. Resident #41 stated she required assistance to put in and maintain her hearing aids. Hearing aids were	F 656	care plan that includes usage of side rails. Resident #¬¬¬¬¬41: Review of resident's care plan last reviewed on 1/10/2023 did not include resident's use of hearing aids. Care plan reviewed and revised on 5/4/2023 by facility minimum data set nurse. Resident has a comprehensive care plan that includes hearing deficit and use of hearing aids Corrective action for residents with the potential to be affected by the alleged deficient practice. All current residents who use side rails and who have hearing deficit, hearing aid usage have the potential to be affected by the alleged practice. By 5/24/2023, an audit will be completed by Director of nursing and nurse support staff to review all current residents for use of side rails. All current residents with side rails will have a review of care plan to verify side rail usage is on the plan of care with revision of plan of care to accurately reflect side rail usage as applicable. This will be completed by 5/24/2023 By 5/24/2023 an audit will be completed by ¬¬¬¬¬¬¬¬¬¬¬¬¬¬¬Director or nursing and nurse support staff to review all current residents for impaired hearing and/or hearing aid use. All current residents with impaired hearing and/or hearing aids, will have a review of current care plan to verify impaired hearing/hearing aid usage is on the plan of care with revision of plan of care to accurately reflect resident hearing status	

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F 656	Continued From page 18 observed on Resident #41's bedside table. A sign was posted in her room regarding applying and maintaining the hearing aids. An interview on 5/4/23 at 1:43 PM with Med Aide #2 revealed that Resident #41 had trouble with hearing and required bilateral hearing aids. Med Aide #2 stated that sometimes the resident wore the hearing aids and sometimes she didn't. An interview with the MDS Nurse on 5/4/23 at 1:54 PM revealed that she was new to the MDS process. The MDS Nurse stated that hearing loss and hearing aids should be included in Resident #41's care plan. The MDS Nurse indicated that areas addressed on the care plan were also listed on the care guide that the Nursing Assistants (NAs) used to provide care. An interview on 5/4/23 at 3:21 PM with NA #5 revealed Resident #41 sometimes wore hearing aids and sometimes she didn't. NA#5 further indicated hearing aids and hearing loss weren't on Resident #41's care guide but should be. An interview on 5/4/23 at 3:38 PM with the Administrator revealed that resident care plans should be accurate and reflect the needs of the residents.	F 656	as applicable. This will be completed by 5/24/2023. Systemic Changes: By 5/24/2023, the regional Minimum data set consultant will inservice the facility Minimum Data Set (MDS) Coordinator and other Interdisciplinary team members that participates in revising care plans. The education will focus on: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set mental psychosocial needs that are identified in the comprehensive assessment to include hearing aids and bed rails/grab bar usage. A comprehensive person centered care plan must be implemented and reviewed for all residents with side rails and hearing impairment/hearing aids. This in service will be completed by 5/24/2023. This information has been integrated into the standard orientation training for employees participating in care planning process and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. 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. To ensure compliance, The Director of Nursing and/or designee will observe 5 residents to evaluate hearing	

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F 656	Continued From page 19	F 656	deficit/hearing aid usage and side rail usage are care planned if applicable. This will be done on weekly basis for 4 weeks then monthly for 3 months using the audit tool titled “Development of Comprehensive Care Plan Audit”. The results of this audit will be 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. Date of Compliance: 5/24/2023	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		5/24/23

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F 689	Continued From page 20 Based on record review, observations, staff and Physician interviews, the facility failed to provide incontinence care safely for a dependent resident (Resident #59) for 1 of 2 residents reviewed for falls. Resident #59 rolled off the bed during care, fracturing her right femur in two places. The findings included: Resident #59 was admitted to the facility on 06/21/2019 with diagnoses to include cerebral infarction (stroke), vascular dementia, and severe aphasia (language disorder caused by damage in a specific area of the brain that controls language expression and comprehension). Review of the care plan initiated on 06/21/2019 and reviewed on 01/31/2023 for Resident #59 revealed a plan of care for activities of daily living (ADL) self-care performance deficit related to stroke. The following intervention was listed for Resident #59: I am totally dependent on staff for repositioning and turning in bed. Review of the Minimum Data Set (MDS) assessment dated 06/24/2022 revealed Resident #59 was severely cognitively impaired. She was totally dependent on the assistance of 2 staff with bed mobility, transfers, and toileting, and was totally dependent on the assistance of 1 staff member for bed bath and personal hygiene. Resident # 59's height was listed as 68 inches (5 feet 8 inches) and her weight was 179 pounds. Review of the electronic medical record for Resident #59 revealed a Nursing Health Status Note written by Nurse #5 on 07/17/2022. The note read in part, "Medication Aide called this nurse to room at 7:30 P.M., Nurse Aide (NA)	F 689	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. F 689 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to provide incontinence care safely for a dependent resident (Resident #59) for 1 of 2 residents reviewed for falls. Resident #59 rolled off the bed during care, fracturing her right femur in two places. Corrective action for resident(s) affected by the alleged deficient practice: For resident #59, the resident was immediately assessed for injury and sent to the ER for evaluation post fall on 7/17/2022 by the hall nurse. The Responsible Party was made aware of the fall by the hall nurse on 7/17/2022. On 7/18/2022, a re-enactment of the fall from the bed was performed by the Certified Nursing Assistant using the administrator as the resident and the Director of Nursing observing. After review of the fall re-enactment, it was determined that the Certified nursing assistant followed the plan of care. It was	

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F 689	Continued From page 21 stated that she was changing her (Resident #59) and accidentally rolled her too far and she fell onto the floor, NA stated that she didn't hit her head when she fell, head to toe assessment complete, vital signs: BP132/70 Pulse 68 Respirations 20 Pulse oximetry (Oxygen saturation level) 97%, no injuries noted visually to head, no visual injuries noted during head to toe, when nurse asked resident if she was hurt she stated "only my arm" resident was left in place on the floor with NA with her and 911 was called at 7:40 P.M. MD (Physician) made aware, Emergency Medical System (EMS) arrived at 8:00 P.M via EMS with stretcher x 2 attendants. Resident continued to be alert. Responsible Party (RP) notified." Review of NA #11's written statement dated 07/17/2022 revealed NA#11 was giving Resident #59 a bed bath. NA #11 finished washing the front of Resident #59's body and had turned her on her left side to wash her back. Resident #59 had some bowel movement on her so NA #11 pushed on the resident's right hip to get all of the bowel movement off of her. NA #11 let go of Resident #59 and was grabbing some more wipes that were at the foot of the bed. NA #11 indicated the next thing she knew Resident #59 was rolling off the bed. NA #11 wrote. "I was trying to grab Resident #59 to keep her from falling out of bed, but it didn't work." Review of the hospital records for Resident # 59 revealed she was admitted to the hospital on 07/18/2022 with diagnosis of comminuted fracture (bone broken in at least 2 places) of the distal right femur. The report read in part, "85-year-old female who has a history of residing in a local skilled nursing facility was getting	F 689	felt that the root cause of the fall was possibly related to the resident reaching for the grab bar that had been removed on 07/14/2022 due to the resident not being able to purposefully use the grab bar. Resident has short- and long-term memory problem with a BIMS of 99. While providing incontinent care the nurse aide did remove her hand from the resident's hip to grab a wipe that was positioned beside her on the bed. It was at this time that the resident rolled forward and the nurse aide was unable to prevent the fall. Interventions, based on the RCA to include a bariatric bed to provide more turning space and the use of a wedge or pillow to be placed on the opposite side during care to prevent a fall from bed. Interventions were put in place on 07/20/2022. On 05/05/2023 the facility identified the resident would benefit from having two persons assist with bed care. Care plan was updated to reflect intervention on 05/05/2023. 1. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning on 5/05/2023, all current residents were audited by the Nurse management team to identify any residents that would benefit from additional turning space and to identify any resident that would benefit from having two-person assistance with bed care. Resident were observed while lying in bed to determine if adequate turning space was available. Staff were observed performing bed care or interviewed about	

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F 689	Continued From page 22 cleaned and accidentally fell hitting the floor with marked facial grimacing. Resident winces in pain with knee range of motion or palpation." Orthopedic surgery evaluated Resident #59 and discussed surgical versus nonsurgical interventions with her family. It was determined to be in the best interest of Resident #59 to hold off on surgery and to fit her with a hinged brace and pain management. She was readmitted to the facility on 07/20/2022. Attempts were made 3 times by phone and text to interview Nurse #5 and NA #11 on 05/02/23 and 05/04/23 without success. An observation of Resident #59 occurred on 05/02/2023 at 2:38 P.M. Resident was lying in a bariatric bed on left side with bilateral half rails intact to upper half of bed. Resident #59 did not open her eyes or respond to verbal stimuli. An interview was conducted with Medication Aide (Med Aide) #2 on 05/02/2023 at 3:20 P.M. Med Aide #2 stated she was working the night that Resident #59 fell out of bed. She further stated that Resident #59 was not on a bariatric bed and did not have side rails on the bed at that time. An interview was conducted with the Physician on 05/03/2023 at 10:49 A.M. The Physician stated that he could not remember the exact circumstances of Resident #59's fall. He further stated that based on her being totally dependent and her weight that at least 2 staff members if not 3 would be indicated when turning and repositioning her. The Physician indicated that pain would be a key factor to go by because the fractured femur was unable to be surgically corrected with a pin because of her comorbidities,	F 689	bed care to determine if two-person assist was indicated for bed care. In addition, the most recent Minimum Data Set Nurse was reviewed for each resident coding for bed care level of assistance. All of these factors were taken into consideration when deciding if additional turning space was indicated or two-person assist was indicated. On 5/09/2023, the Nurse Management team reviewed the findings of this audit with the Interdisciplinary team. This audit was finalized on 05/09/2023. Results included: 1 residents needed a bariatric bed. 1 resident needed a longer bed. 5 resident identified 2 person assist for bed mobility. On 5/09/2023 the Director of Nursing and Minimum Data Set Nurse completed corrective action to include: 2 person assist with bed mobility. On 5/05/2023 the nurse management team audited to identify all current residents who had their grab bar discontinued in the last 7 days. This was completed by running an order listing report in the electronic health record to identify the discontinued grab bar orders. On 5/08/2023, the Nurse management team re-evaluated the need for the discontinued grab bars. Re-evaluation was completed by interviewing the resident regarding their preference for grab bar use and their ability to safely use the grab bar by having the resident demonstrate use of the grab bar. For those residents unable to be interviewed	

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F 689	Continued From page 23	F 689		

and therefore she may still have pain when turned and repositioned.

A telephone interview was conducted on 05/03/23 at 12:56 P.M. with the Director of Nursing (DON) that was working at the facility at the time of the incident in July 2022. The former DON stated that NA #11 was providing incontinence care when the fall occurred. She further stated that staff were educated on determining if a resident was a 2 person assist and when to call for help. The former DON indicated that she could not remember the specific dates or topics of the education that were provided.

An interview was completed with NA #6 on 05/03/2023 at 5:00 P.M. NA #6 stated that she always has another person help her when she is providing care for Resident #59. She further stated that she usually works 11-7 shift. She indicated that she was working the night that Resident #59 fell. NA# 6 stated that she had told NA #11 to wait for her to help her that night and she hadn't waited, and Resident #59 fell on the floor.

An interview was conducted with the Administrator on 05/04/2023 at 08:30 A.M. The Administrator stated that the facility had a plan of correction that was completed at the time of the fall. She further stated the root cause analysis had been determined to be the bed was not large enough for Resident #59 to turn in safely, and so the facility replaced the bed with a bariatric bed with half rails. The Administrator indicated that Resident #59 did not require the assistance of 2 staff members for care. She stated that some of the nurse aides worked together as a team and teamwork was encouraged, but there were plenty

due to cognition, a sample of the staff were interviewed across all 3 shifts to determine if the resident could safely use the grab bar. This was completed on 05/05/2023. Any resident identified as benefitting from the use of a grab bar were care planned to use the grab bar, medical provider order was obtained, and a side rail consent form was initiated with the R/P. In addition, a device and bed rail user define assessment were completed to document the safety review05/05/2023. The results included: nothing was identified
On 5/09/2023 the Director of Nursing, Minimum Data set nurse and Unit managers completed corrective actions to include: no deficient practice identified for grab bars

All residents were in compliance on 5/24/2023.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 5/4/2023 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: preventing falls from bed. This education was provided by the Nurse management team.
- Preventing falls from bed during bed care
- Gathering supplies prior to care
- Positioning using wedges and pillows
- Accessing Kardex prior to care

The DON will ensure that any of the

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F 689	Continued From page 24 of seasoned nurse aides at the facility that did not require assistance when providing care for Resident #59. The Administrator further stated that audits and education had been provided by the facility at the time of the incident. The audit for dependent residents to determine whether they required 2 persons assist or 1 person assist was conducted on 07/18/2022. The inservice education that was provided by the facility was dated 07/18/22-07/19/22. The Administrator stated the IDT (Interdisciplinary Team) had met on 07/18/2022, 07/19/2022, and 07/20/2022 to discuss the incident and the interventions. The Administrator stated that the facility had not conducted ongoing monitoring because she didn't think NA #11 had done anything wrong. She further stated that the fall was an unfortunate accident that had occurred, but the bariatric bed and the side rails were working because Resident #59 had not had any more falls.	F 689	above identified staff who does not complete the in-service training by 05/24/2023 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 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 DON or designee will complete a QA Monitor for F689 that will consist of observing staff providing bed care to residents and observe for safety techniques and following the Kardex for interventions for bed care. This monitor will be completed weekly x 2 weeks then monthly x 3 months. Reports of the monitor will be given by the Director of Nursing to the weekly Quality of Life – Quality Assurance committee and corrective, technique, and following the Kardex for number of assistances required for bed care. The Quality of Life committee consists of the Director of Nursing, Administrator, Assistant Director of Nursing, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimum Data Set Nurse and Health Information Management and meets weekly. Date of Compliance: 5/24/2023	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)	F 732		5/24/23

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F 732	Continued From page 25 §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 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 observations, record review and staff	F 732	The statements made on this plan of	

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F 732	Continued From page 26	F 732		

interviews the facility failed to record the correct resident census (number of residents in a certified bed) for 18 out 18 daily nursing staff posting forms reviewed.

Findings included:

The daily nursing staff posting forms from 04/17/23 through 05/04/23 revealed the following census numbers were recorded:

Date	Census #
4/17	95
4/18	96
4/19	97
4/20	97
4/21	98
4/22	99
4/23	99
4/24	99
4/25	102
4/26	100
4/27	99
4/28	100
4/29	100
4/30	100
5/01	102
5/02	102
5/03	103
5/04	103

An interview with the Administrator on 05/01/23 at 4:00 PM revealed the total number of certified beds in the facility was 89.

A phone interview was conducted with the Scheduler on 05/04/23 at 3:00 PM. The Scheduler reported she always put the total

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.
F 732
The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited:
The facility failed to record the correct resident census (number of residents in a certified bed) for 18 out of 18 daily nursing staff posting forms reviewed.
The plan for correcting the specific deficiency and the process that led to the alleged deficiency:
On 5/05/2023 the Director of Nursing and Unit Managers and Nursing Secretary were educated by Administrator on the guidelines for daily staffing posting to include the following:
The facility must post the following information on a daily basis:
1. Facility name
2. The current date
3. 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. To include: RN, LPN, Certified NA.
4. Resident Census for Certified Beds only

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F 732	Continued From page 27 number of all of the beds on the daily nursing staff posting form which included assisted living beds. She stated she received an email daily from the Admissions Nurse each day with the total number of residents and she used that number to record on the daily nursing staff posting form. She stated she did not know that she was supposed to separate assisted living beds and the certified beds. An interview was conducted with the Administrator on 05/04/23 at 3:22 PM. The Administrator confirmed the daily nursing staff posting form was inaccurate and should have only included the residents in certified beds. She stated she would need to provide additional education and training on completing the daily nursing staff posting accurately to reflect only the staffing needs for certified beds.	F 732	Posting requirement: Must be posted clearly and readable format and in a prominent place readily accessible to residents and visitors. The facility must document accurate information on the daily nurse staffing sheets. This includes daily verifying the schedule/assignment sheet reports and the daily Post Nursing Staffing information sheets are correct and match. On 5/05/2023 the Administrator implemented the required changes to the daily staffing posting with the nursing team. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: On 5/16/2023 the Administrator reviewed Daily census for certified beds and staffing assignment sheet and verified the Daily staff Posting sheet was updated in accordance with the guidelines for the staffing posting. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Director of Nurses and/or the Administrator will review the daily staffing posting for accuracy. This will be done daily by DON or designee. The Administrator of designee will complete the Quality Assurance audit tool for adherence to facility policy and process weekly x 4 then monthly X3 utilizing the	

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F 732	Continued From page 28	F 732	F732 Quality Assurance Tool. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nursing to ensure that corrective action for any concerns are initiated and monitored as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly x 4 then monthly x3 Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. Date of Compliance: 5/24/23	
F 761 SS=E	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	F 761		5/24/23

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F 761	Continued From page 29 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 observations, record review and staff interviews the facility failed to follow the manufacturer's guidelines to discard oral inhaler vial solutions after one week of being exposed to light and to record an opened date on the package (100 hall cart), failed to secure and label loose pills (100, 200 and 400 hall carts), failed to record an opened date on two insulin (medication to treat diabetes) pens (200 hall cart), failed to store the correct resident's insulin pens in the assigned storage devices for Resident #28 and #68 (200 hall cart), failed to discard expired medication (400 hall cart), and failed to keep unattended medications in a locked medication cart (100 hall cart). These observations were for 3 of 6 medication carts observed for medication storage. Findings included: 1. The manufacturers' guidelines for Ipratropium Bromide and Albuterol Sulfate inhalers stated to keep out of light and dispose after one week if exposed to light. An observation of the 100 hall medication cart on 05/03/23 at 8:10 AM along with Medication Aide (MA) #1 revealed there were 3 doses of oral inhaler vial solutions, Ipratropium Bromide and Albuterol Sulfate (a treatment for chronic	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 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 F 761 The facility failed to follow the manufacturer's guidelines to discard oral inhaler vial solutions after one week of being exposed to light and to record an opened date on the package (100hall cart), failed to secure label loose pills (100, 200 and 400 hall carts), Failed to record an opened date on two insulin (medication to treat diabetes) pens (200 hall cart), Failed to store the correct resident's insulin pens in the assigned storage devices for Resident #28 and #68 (200 hall cart), failed to discard expired medication (400 hall cart), and failed to keep unattended medications in a locked medication cart (100 hall cart). 1. Corrective action for resident(s)	

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F 761	Continued From page 30 obstructive pulmonary disease) exposed to light in an opened foil package with no opened date labeled. Further observation of the 100 hall medication cart revealed there were more than could be counted unidentifiable loose pills observed at the bottom of 3 of 3 medication cart drawers. An interview with MA #1 at 8:12 AM on 05/03/23 revealed she believed the night shift nursing staff was supposed to check the carts for expired medications and cleaning the carts. She stated she was not aware the Ipratropium Bromide and Albuterol Sulfate inhaler solutions should not have been exposed to light. MA #1 stated she should have dated the package of inhalers when she opened them and secured the unused inhalers in the foil pack provided. MA #1 stated she did not know the unidentified loose pills were at the bottom of drawers in the medication cart. An interview was conducted with the Director of Nursing (DON) on 05/04/23 at 3:37 PM. The DON reported all nursing staff should be checking to be sure the oral inhaler vial solutions are stored according to the manufactures' guidelines and the medication carts should be cleaned on a daily basis. 2. Review of the manufacturer's instructions for Lantus Insulin and Glargine Insulin revealed to discard after 28 days after opening. An observation of the 200 hall medication cart on 05/03/23 at 8:35 AM along with Unit Manager #1 revealed: a Lantus (long acting insulin) pen was opened with no recorded opened date, more than could be counted unidentified loose pills at the bottom of 3 of 3 medication drawers of the	F 761	affected by the alleged deficient practice: On 5/3/23 Medication aide #1 (100 hall medication cart) disposed of the oral inhaler vial solutions that were exposed to light in an open foil package with no opened date labeled per manufacturer's guidelines. On 5/3/23 Medication aide #1 (100 hall medication cart) discarded the unidentifiable loose pills observed at the bottom of 3 of 3 medication cart drawers of the medication cart. On 5/3/23 Unit Manager #1 (200 hall medication cart) discarded open Lantus with no recorded opened date per manufacturer's instructions. On 5/3/23 Unit Manager #1 (200 hall medication cart) discarded more than could be counted unidentified loose pills at the bottom of 3 of 3 medication drawers of the medication cart. On 5/3/23 Unit Manager #1 (200 hall medication cart) disposed of both insulin pens for resident #28 and resident #68 that were found to be stored in incorrect cylinder storage containers. On 5/3/23 Nurse #2 (400 hall medication cart) disposed of undated Lispro insulin pen per manufacturer's instructions. On 5/3/23 Nurse #2 (400 hall medication cart) disposed of the expired acetaminophen per manufacturer's instructions. 5/3/23 Nurse #2 (400 hall medication cart) disposed of two unidentified pills stored loosely in medication cup in the top drawer per the manufacturer's instructions. 5/3/23 Nurse #2 (400 hall medication cart)	

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F 761	Continued From page 31 medication cart, and Resident #28's Glargine (long acting insulin) pen was found to be stored in Resident #68's cylinder storage container and Resident #68's Glargine was stored in Resident #28's cylinder storage container. Both Glargine Insulin pens for Resident #28 and #68 were opened and dated 05/02/23. An interview with Unit Manager #1 on 05/03/23 at 8:35 AM revealed that all nursing staff should be checking their medications carts for expired meds, ensuring all products were dated when opened and making sure the carts were clean and organized. She stated she was helping out Nurse #1 at this time and she was not usually on a medication cart. She stated whoever opened the Lantus insulin pen should have dated it because it was only good for 28 days after opening. The Unit Manager stated with regard to the Glargine Insulin pens that neither Resident #28 nor Resident #68 had received any insulin today. The Unit Manager confirmed that there was a mix up when storing the Glargine Insulin pens back in the cylinders. The Unit Manager revealed the Glargine Insulin pens were noted to be full and they were both opened on 05/02/23. She disposed of both insulin pens immediately in the needle dispensing container. An interview was conducted with the DON on 05/04/23 at 3:37 PM. The DON reported all nursing staff should be checking to be sure all medications and insulin pens that were opened should be dated, the medication carts should be cleaned on a daily basis and she expected nursing staff to be responsible when storing insulin pens and ensuring they have the right drug for the right resident to avoid medication errors.	F 761	disposed of more than could be counted unidentified loose pills at the bottom of 3 of 3 medication drawers of medication cart. On 5/3/23 Medication aide #1 (100 hall medication cart) secured and locked the unlocked medication cart. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 05/17/2023 the Director of Nurses / Unit Managers audited all medication carts to ensure that all oral inhaler vial solutions foil package dated when opened and disposed of per manufacture's guidelines after one week. The results included: 600/700 no deficient practice 400/500 had 0 deficient practice 100 hall had 3 undated 200 hall had 0 deficient practice On 05/17/2023 the Director of Nurses/Unit managers audited all medication carts to ensure that all Insulin pens dated, labeled and stored in the correct cylinder storage container. The results included: 600/700 hall had 1 deficient practice. 400/500 hall 0 deficient practice 200 hall had 0 deficient practice 100 hall 2 out of date On 05/17/2023 the Director of Nurses/ Unit Managers audited all medication carts to ensure clean with no unidentifiable loose pills in the medication drawers and or in medication cups. The results included: 600/700 hall had 0 deficient practice 400/500 hall 0 deficient practice 200 had 0 deficient practice 100 hall had 0 deficient practice On 05/17/2023 the Director of Nurses/Unit	

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F 761	Continued From page 32 3. Review of the manufacturer's instructions for Lispro Insulin revealed to discard after 28 days after opening. An observation of the 400 hall medication cart on 05/03/23 at 9:50 AM along with MA #2 revealed: a Lispro (long acting insulin) pen was opened with no recorded date, a ½ bottle of acetaminophen (pain relieving medication) was expired on 03/23/23, two unidentified pills stored loosely in a medication cup in the top drawer of the medication cart, and more than could be counted unidentified loose pills at the bottom of the 3 of 3 of the medication drawers. An interview with MA #2 on 05/03/23 at 9:50 AM revealed she had no idea who put the loosely stored unidentified pills in the medication cup and left them in the top drawer. She stated she did not notice them sitting in the cup. MA #2 also stated she did not notice the acetaminophen bottle had expired. MA #2 reported she did not administer any acetaminophen from that bottle today. She stated she did not administer insulin because she was a Medication Aide and added that a nurse would have to be asked about the insulin and about how often medication carts were cleaned out. She stated she did not clean out the medication cart. An interview was conducted with Nurse #2 on 05/03/23 at 10:00 AM. Nurse #2 reported she believed the medication carts were cleaned and checked once a month by the night nurses. She stated whenever she opened any insulin pens she would put a date on the insulin pen when it was opened. Nurse #2 stated she was not sure if she opened the Lispro Insulin or not, but the date should have been written on the pen because it	F 761	Mangers audited all medication carts for any expired medications or opened insulin pens for presence of labeling with the opening date. The results included: 600/700 hall had 0 deficient practice 400/500 hall 0 deficient practice 200 hall 0 deficient practice 100 hall 1 deficient practice On 05/17/2023 the Director of Nurses / Unit Managers audited all medication carts to ensure locked. The results included: 600/700 hall had 0 deficient practice 400/500 0 deficient practice 200 hall 0 deficient practice 100 hall 0 deficient practice. On 5/17/2023 the Director of Nurses/ Unit managers completed corrective action of: disposing all items of deficient practice Medication carts were audited by the pharmacy consultant on 05/18/2023. The results included: 100/300 eye drop out of date 200 hall pulled eye drops, house stock out of stock items, 2 loose pills found, 400 hall 2 insulin pins not in holders, 2 insulin pens in different holders, 1 inhaler not dated, 500 hall 1 inhaler found out of pack, 600/700 insulin out of date, eye drop pulled out of date, OTC not dated. On 5/18/2023 the pharmacy consultant completed corrective action of discarding all identified items. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 5/17/2023 the Director of Nurses and Staff Development Coordinator began education of all Full Time, Part Time, as needed nurses, medication aides and	

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F 761	Continued From page 33 would need to be discarded 28 days after opening. An interview was conducted with the DON on 05/04/23 at 3:37 PM. The DON stated all nursing staff should be checking to be sure there were no expired medications, all medications and insulin pens that were opened should be dated, and the medication carts should be getting cleaned on a daily basis. 4. A continuous observation of the medication cart on the 100 hall on 05/03/23 at 1:00 PM until 1:07 PM revealed the medication cart was unlocked and stationed in the hallway. Five staff members were observed walking pass the medication cart. An interview was conducted with Medication Aide #1 on 05/03/23 at 1:07 PM. She stated she usually locked the cart whenever she stepped away from it and she forgot to lock it this time. An interview was conducted with the DON on 05/04/23 at 3:37 PM. The DON stated all nursing staff should be securing their medications carts whenever they were not in use.	F 761	agency nurses on facility policy related to medication safety that included safely securing and storing medications, labeling of the date on opened insulin pens and checking expiration dates on medications to assure no expired medications are administered. Education will be completed by 5/24/2023. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the above nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 5/24/2023. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee for F761 Adequate Label/Store Drugs and Biologicals to assess that all medications are safely and appropriately stored, that all opened insulin pens are dated and no expired insulin pens are on the medication cart. Audits of medication carts to ensure locked, no loose unidentifiable pills, safe storage of medications, appropriate dating of insulin pens and correct cylinder storage container for each pen and oral inhaler vial solutions dated, stored and disposed of per manufacturers' guidelines will be	

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F 761	Continued From page 34	F 761	completed weekly x 2 and monthly x 3 or until resolved for compliance with this process. Reports will be presented to the weekly Quality Assurance Committee by the Director of Nursing 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 Quality assurance Meeting is attended by the Administrator, Director of Nursing, Activity Director, Dietary Manager, Therapy Manager, Minimum Data Set Coordinator, Health Information Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 5/24/2023	
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.	F 812		5/24/23

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F 812	Continued From page 35 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to remove expired and spoiled food items stored for use in the walk-in refrigerator and failed to label, date leftover food and remove expired food items for 1 of 2 nourishment rooms observed (400 Hall nourishment room). This practice had the potential to affect the food served to the residents. The findings included: 1. Observation in the kitchen on 5/01/23 at 11:58 AM revealed the following in the walk-in refrigerator: an opened container of honey thick apple juice with a label on it which indicated prep date of 4/11/23 and use by date 4/12/23. Manufacturer label indicated after opening, may be kept up to 7 days under refrigeration. an opened box of red peppers with large patches of visible white, fuzzy mold on 3 of the peppers. The opened date on the box was 4/6/23. an opened package of ham with a prep date of 4/25/23 with no discard or expiration date on the label. Interview on 5/1/23 at 12:05 PM with the Dietary Manager (DM) revealed she thought the opened	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 05/01/2023. During initial walk through of the kitchen on 5/01/2023, it was noted dietary services had failed to properly date items with use by dates and discard out of date honey thickened liquids, red peppers, and ham. The Dietary Service Director discarded the items 5/01/2023. During observation of the 400 Hall nourishment room on 5/01/2023 the fridge was noted to have dried applesauce on the door and multiple areas of dried liquids on the bottom interior. It was also noted that staff failed to properly store multiple items: an opened container of nectar thick juice, opened container of nectar of water, opened coffee creamer,	

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F 812	Continued From page 36 containers of thickened liquids were good for 3 months after opened and that her staff had put the wrong date on the container. DM stated she did not realize the peppers had mold on them and did not know why there was not a discard date on the package of ham. DM stated that items in the walk-in refrigerator were to be checked daily and expired items were to be removed immediately. DM further stated the procedure for labeling food to store once opened was that it was to be wrapped in plastic and labeled with an opened and a discard date. 2. Observation of the 400 hall Nourishment Room on 5/2/23 at 2:15 PM revealed the following: an opened container of nectar thick water with no opened or discard date on it. an opened container of nectar thick apple juice with no opened or discard date on it. an opened container of vanilla almond coffee Creamer with an opened date of 3/2/23. an opened gallon plastic container of iced tea with printed expiration date on the container of April 17, 23 with no opened date. a plastic container with visibly old food item that was unidentifiable with no name or date on the container. Notice on the refrigerator in the nourishment room indicated: No employee items should be placed in the nourishment room refrigerators.	F 812	opened and expired sweet tea, and an unlabeled disposable container of visibly old leftovers. The Dietary Service Director discarded all noted items and Environmental Services cleaned the fridge. 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 5/18/2023, the Dietary Service Director completed a kitchen walk through to ensure all food items were within their dates and dated properly. On 5/18/2023 the Dietary Manager visited all nourishment rooms to ensure all items in nourishment fridge and surrounding areas were labeled, dated, and stored properly. On 5/18/2023 environmental services staff cleaned all nourishment fridges. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary, environmental, and nursing staff on 5/18/2023 by Dietary Service Director. Topics included: • Storage and dating policies and regulations. • Shift inspections to observe all food are within their dates and tossed if out of date. • Shift inspections to observe nourishment room items are with their	

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F 812	Continued From page 37 All resident items placed in refrigerator should have name and date. All items should be taken out of boxes prior to placing in the refrigerators. Interview on 5/2/23 at 2:15 PM with Nursing Assistant (NA) #4 revealed when a family brought in food for a resident the nursing staff labeled and dated it before putting it in the nourishment room refrigerator. NA #4 further stated she was not exactly sure how long food was stored in the refrigerator. NA #4 stated she was not sure who discarded foods that were expired and was responsible for cleaning out the nourishment room refrigerator. Interview on 5/2/23 at 3:37 PM with NA #5 indicated when food was brought in by family or visitors it was to be labeled and dated prior to placing it in the nourishment room refrigerator. NA #5 further stated she thought housekeeping cleaned out the refrigerators, but she was not sure. She stated she thought food stayed in the refrigerator for 7 days before it was discarded but stated she was not sure. Interview on 5/2/23 at 4:31 PM with the Dietary Manager revealed she did not check the nourishment rooms for expired items. Dietary Manager stated the nursing staff were reminded to label all items that were brought in, and they were to be dated when opened. Dietary Manager stated housekeeping was supposed to check the dates on the items in the nourishment room refrigerator and discard any expired items. The Dietary Manager stated if an item was not labeled or dated housekeeping staff were instructed to discard it.	F 812	dates and/or stored properly. • Policies and practices for nourishment room scheduled cleaning. 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. Dietary staff will monitor proper food storage in the nourishment room while restocking nourishment rooms on AM and PM shifts. Environmental staff will monitor nourishment room cleanliness by cleaning per daily checklist. 4. Quality Assurance monitoring procedure. The Dietary Service Director will monitor procedures for proper food storage weekly x 4 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that all food is labeled, dated, and stored properly in the kitchen and in the nourishment rooms. 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 weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator,	

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F 812	Continued From page 38 Interview on 5/4/23 at 3:41 PM with the Administrator revealed the refrigerators should be free from expired items. The Administrator further stated she expected that all out of date items would be discarded immediately.	F 812	Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Compliance date: 5/24/23	
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. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		5/24/23

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F 867	Continued From page 39 §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. §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	F 867		

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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:

(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

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	345207	A. BUILDING _____ B. WING _____	C 05/04/2023

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LIBERTY COMMONS N&R CTR OF COLUMBUS CTY	1402 PINCKNEY STREET WHITEVILLE, NC 28472

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F 867	Continued From page 41 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility's Quality Assurance and Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following the focused infection control and complaint investigation survey of 12/10/20 and a recertification and complaint investigation survey of 4/5/22. This was for 3 recited deficiencies on the current recertification and complaint investigation survey of 5/4/23 in the areas of resident assessments (F641), label/store drugs and biologicals (F761) and food storage (F812). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance program. Findings included: This tag is cross referenced to: F641 Based on record review, resident and staff interviews, and observation the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of 1.) bed rails (Resident #59); 2). vision and hearing (Resident #41) and 3). tobacco use (Resident #60) for 3 of 19 residents reviewed for accuracy of MDS assessments. During the 12/10/20 focused infection control and complaint investigation, the facility failed to code the MDS assessment accurately in the area of lower extremity impairment status.	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 the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the focused infection control and complaint investigation survey of 12/10/20 and a recertification and complaint investigation survey of 4/5/22. This was for 3 recited deficiencies on the current recertification and complaint investigation survey of 5/4/2023 in the areas of resident assessments (F641), Label/Store drugs and biologicals (F761) and Food storage (F812) 1.Corrective action for resident(s) affected by the alleged deficient practice: F641: Resident #59 Minimum data set quarterly assessment with Assessment Reference date of 3/31/2023 reviewed and resident does not have side rails	

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F 867	Continued From page 42 During the 4/5/22 recertification and complaint investigation survey the facility failed to accurately code the MDS assessment in the areas of behaviors for refusal of care, speech, and falls. An interview on 5/4/23 at 3:38 PM with the Administrator revealed that MDS assessments should be accurate and reflect the needs of the residents. The Administrator indicated that the MDS Nurse was new to the MDS process and further education was needed. F761 Based on observations, record review and staff interviews the facility failed to follow the manufacturer's guidelines to discard oral inhaler vial solutions after one week of being exposed to light and to record an opened date on the package (100 hall cart), failed to secure and label loose pills (100, 200, 400 hall carts), failed to record an opened date on two insulin (medication to treat diabetes) pens (200 hall cart), failed to store the correct resident's insulin pens in the assigned storage devices for Resident #28 and #68 (200 hall cart), failed to discard expired medication (400 hall cart), and failed to keep unattended medications in a locked medication cart (100 hall cart). These observations were for 3 of 6 medication carts observed for medication storage. During the 4/5/22 recertification and complaint investigation survey the facility failed to dispose of 7 individual packages of expired medications and failed to properly store 4 tablets in the original package to indicate what the expiration date was. An interview on 5/4/23 at 3:30 PM with the Administrator revealed it was an ongoing process	F 867	coded on the MDS. Updated side rail assessment was completed on resident and per staff completing assessment the rail usage is not a restraint for this resident Resident #41 Minimum data set assessment with Assessment reference date of 1/27/2023 was modified and corrected by the facility Minimum data set Nurse on 5/22/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment. Resident #60 Minimum data set assessment with Assessment reference date of 1/10/2023 was modified and corrected by the regional minimum data set consultant on 5/22/2023 and the resident’s tobacco use status in Section J was corrected to reflect resident’s current tobacco use during the Assessment reference date lookback timeframe. F761: On 5/3/23 Medication aide #1 (100 hall medication cart) disposed of the oral inhaler vial solutions that were exposed to light in an open foil package with no opened date labeled per manufacturer’s guidelines. On 5/3/23 Medication aide #1 (100 hall medication cart) discarded the unidentifiable loose pills observed at the bottom of 3 of 3 medication cart drawers of the medication cart. On 5/3/23 Unit Manager #1 (200 hall medication cart) discarded open Lantus with no recorded opened date per manufacturer’s instructions. On 5/3/23 Unit Manager #1 (200 hall	

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F 867	Continued From page 43 to be sure there were no expired medications on the medication carts. She stated the Director of Nursing (DON) was new to her position at the facility. Administrator further stated the facility needed to improve systems currently in place and determine the reason why the previous systems did not work. F812 Based on record review, observations and staff interviews the facility failed to remove expired and spoiled food items stored for use in the walk-in refrigerator and failed to label, date leftover food, and remove expired food items for 1 of 2 nourishment rooms observed (400 Hall nourishment room). This practice had the potential to affect the food served to the residents. During the 4/5/22 recertification and complaint investigation survey the facility failed to ensure the sanitization solution strength used in a three-compartment sink and in 3 red buckets used to sanitize the kitchen countertops was within the manufacturer's recommendation. An interview on 5/4/23 at 3:30 PM with the Administrator revealed ongoing monitoring and education was required to ensure that expired items were not in the refrigerators or freezers and that they were not served to residents.	F 867	medication cart) discarded more than could be counted unidentified loose pills at the bottom of 3 of 3 medication drawers of the medication cart. On 5/3/23 Unit Manager #1 (200 hall medication cart) disposed of both insulin pens for resident #28 and resident #68 that were found to be stored in incorrect cylinder storage containers. On 5/3/23 Nurse #2 (400 hall medication cart) disposed of undated Lispro insulin pen per manufacturer's instructions. On 5/3/23 Nurse #2 (400 hall medication cart) disposed of the expired acetaminophen per manufacturer's instructions. 5/3/23 Nurse #2 (400 hall medication cart) disposed of two unidentified pills stored loosely in medication cup in the top drawer per the manufacturer's instructions. 5/3/23 Nurse #2 (400 hall medication cart) disposed of more than could be counted unidentified loose pills at the bottom of 3 of 3 medication drawers of medication cart. F812: During initial walk through of the kitchen on 5/01/2023, it was noted dietary services had failed to properly date items with use by dates and discard out of date honey thickened liquids, red peppers, and ham. The Dietary Service Director discarded the items 5/01/2023. During observation of the 400 Hall nourishment room on 5/01/2023 the fridge was noted to have dried applesauce on the door and multiple areas of dried	

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F 867	Continued From page 44	F 867		

liquids on the bottom interior. It was also noted that staff failed to properly store multiple items: an opened container of nectar thick juice, opened container of nectar of water, opened coffee creamer, opened and expired sweet tea, and an unlabeled disposable container of visibly old leftovers. The Dietary Service Director discarded all noted items and Environmental Services cleaned the fridge.

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.
F641:
All residents have the potential to be affected by the alleged deficient practice.
A 100 % audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents who use tobacco, use hearing aids/sound amplifiers, and those that have side rails/grab bars that meet the definition of restraint will be completed in order to identify if the following questions were coded accurately in the section of B0200, B0300, J1300, P0100A on the Minimum data set assessment:

- B0300 – Hearing aid
- J1300 – Tobacco use
- P0100A – Bed Rail

This audit will be completed by regional

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F 867	Continued From page 45	F 867	Minimum data set consultant no later than 05/24/2023. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator. Any necessary Minimum data set corrections will be completed no later than 05/24/2023 F761: On 05/17/2023 the Director of Nurses / Unit Managers audited all medication carts to ensure that all oral inhaler vial solutions foil package dated when opened and disposed of per manufacture's guidelines after one week. The results included: 600/700 no deficient practice 400/500 had 0 deficient practice 100 hall had 3 undated 200 hall had 0 deficient practice On 05/17/2023 the Director of Nurses/Unit managers audited all medication carts to ensure that all Insulin pens dated, labeled and stored in the correct cylinder storage container. The results included: 600/700 hall had 1 deficient practice. 400/500 hall 0 deficient practice 200 hall had 0 deficient practice 100 hall 2 out of date On 05/17/2023 the Director of Nurses/ Unit Managers audited all medication carts to ensure clean with no unidentifiable loose pills in the medication drawers and or in medication cups. The results included: 600/700 hall had 0 deficient practice 400/500 hall 0 deficient practice 200 had 0 deficient practice 100 hall had 0 deficient practice	

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F 867	Continued From page 46	F 867	On 05/17/2023 the Director of Nurses/Unit Mangers audited all medication carts for any expired medications or opened insulin pens for presence of labeling with the opening date. The results included: 600/700 hall had 0 deficient practice 400/500 hall 0 deficient practice 200 hall 0 deficient practice 100 hall 1 deficient practice On 05/17/2023 the Director of Nurses / Unit Managers audited all medication carts to ensure locked. The results included: 600/700 hall had 0 deficient practice 400/500 0 deficient practice 200 hall 0 deficient practice 100 hall 0 deficient practice. On 5/17/2023 the Director of Nurses/ Unit managers completed corrective action of: disposing all items of deficient practice Medication carts were audited by the pharmacy consultant on 05/18/2023. The results included: 100/300 eye drop out of date 200 hall pulled eye drops, house stock out of stock items, 2 loose pills found, 400 hall 2 insulin pins not in holders, 2 insulin pens in different holders, 1 inhaler not dated, 500 hall 1 inhaler found out of pack, 600/700 insulin out of date, eye drop pulled out of date, OTC not dated. On 5/18/2023 the pharmacy consultant completed corrective action of discarding all identified items. F812: All residents have the potential to be affected by the alleged deficient practice. On 5/18/2023, the Dietary Service Director completed a kitchen walk through	

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F 867	Continued From page 47	F 867	to ensure all food items were within their dates and dated properly. On 5/18/2023 the Dietary Manager visited all nourishment rooms to ensure all items in nourishment fridge and surrounding areas were labeled, dated, and stored properly. On 5/18/2023 environmental services staff cleaned all nourishment fridges. The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 5/15/2023 to review the deficiencies from the May 1, 2023 to May 4, 2023 annual recertification survey, CI survey, and reviewed the citations. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 5/18/2023 , the Nurse Clinical 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. On 5/18/2023 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 committee to include identifying any issues identified including correcting	

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F 867	Continued From page 48	F 867	repeat deficiencies. 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 5/24/2023 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 4 weeks then monthly x 6 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 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: 05/24/2023	