STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(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 and complaint investigation survey was conducted on 06/05/-06/08/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Z78811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/5-6/8/2023. Event ID# Z78811. The following intakes were investigated NC00202059, NC00196011, NC00196871, NC00196965, NC00198332, NC00200362, NC00200980, NC00200723, NC00196849, and NC00196956. 4 of 25 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		7/6/23

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

Electronically Signed | 06/30/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews, the facility failed to notify the physician of the resident refusals to wear compression hose for 1 of 3 residents investigated for non-pressure related skin issues (Resident #24).	F 580	1. Resident #24 currently resides in the Center completing usual activities of daily living. Resident #24 TED hose order was discontinued on 6/27/2023 after Inter Disciplinary Team (IDT) review. 2. An audit was completed by Director of Nursing (DON)/Designee on 6/27/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 The findings included: Resident #24 was admitted to the facility on 6/30/2021 with diagnoses to include unspecified lymphedema (swelling of an extremity caused by accumulation of fluid) and hypertension. A physician order for Resident #24 dated 1/10/2023 ordered to apply compression hose in the morning and remove the hose at night. The most recent Quarterly Minimum Data Set (MDS) assessment dated 5/5/2023 assessed Resident #24 to be severely cognitively impaired. The MDS assessed Resident #24 to require supervision of one person for dressing. The MDS documented Resident #24 did not refuse care. A review of the medication administration record for June 2023 revealed that compression hose was documented as applied on 6/5/2023 by Nurse #4 and 6/7/2023 by Nurse #1. It was documented on the medication administration record that Nurse #3 removed Resident #24's compression hose on 6/6/2023 in the evening. The electronic medical record was reviewed and there was no communication documented with the physician related to refusal of compression hose. Resident #24 was observed on 6/5/2023 at 12:15 PM. Resident #24 was sitting on the side of the bed with her legs dangling. Both legs appeared swollen and Resident #24 was not wearing compression hose. When asked about her legs, Resident #24 stated, "Yes, they are very swollen today."	F 580	of in-house residents with physician's orders for the application of TED hose. 5 residents with TED hose audited with no issues found. 3. Education will be provided by DON/Designee to nurses regarding the proper Doctor (MD)/Responsible Party (RP) notification and documentation of resident refusals. Education will be completed by 7/6/2023. 4. DON/Designee to audit for MD/RP notification related to resident refusals 3 times a week for 3 months to ensure MD orders are being followed as prescribed. Results of the audits will be reviewed in Monthly Quality Assurance/Performance Improvement meetings and monitored ongoing as needed to ensure continued compliance. New hires will be educated on proper MD/RP notification and documentation of resident refusals during Department Orientation. DON responsible for Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

An observation of Resident #24 was conducted on 6/7/2023 at 9:07 AM. Resident #24 was sitting up in a chair wearing a dress. Her lower legs were swollen, and she did not have compression hose on her legs. Resident #24 stated, "I never wear any kind of hose," when asked about the compression hose.

Nursing assistant (NA) #1 was interviewed on 6/7/2023 at 9:13 AM. NA #1 reported that Resident #24 was able to dress herself without assistance and she refused staff help most of the time. NA #1 reported Resident #24 did not wear compression hose.

An interview was conducted with NA #2 on 6/7/2023 at 9:39 AM. NA #2 reported that Resident #24 would not allow staff to assist her to dress, and she did not wear compression hose.

Nurse #1 was interviewed on 6/7/2023 at 9:39 AM. Nurse #1 reported he had not notified the physician that Resident #24 refused the application of compression hose.

The Nurse Practitioner (NP) was interviewed on 6/7/2023 at 12:29 PM. The NP reported he was not aware that Resident #24 refused to wear compression hose. The NP explained neither he nor the physician were aware Resident #24 would not wear compression hose. The NP reported he would have changed the orders to better accommodate the resident.

Nurse #3 was interviewed on 6/7/2023 at 3:08 AM. Nurse #3 reported she had not notified the physician that Resident #24 refused to wear the compression hose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 Nurse #4 was interviewed by phone on 6/7/2023 at 3:48 PM. Nurse #4 reported that "sometimes" she documented that Resident #24 refused to have the compression hose applied. Nurse #4 reported she had not notified anyone of the resident's refusal to wear compression hose. An interview was conducted with the Director of Nursing (DON) on 6/8/2023 at 1:10 PM. The DON explained that she did not know why the nursing staff had not notified the physician of Resident #24's refusal to wear compression hose. The DON reported she expected staff to call and report resident refusals to the physician and receive order changes.	F 580		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6	F 623		

and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide the resident and/or responsible party (RP) written notification of the reason for a hospital transfer for 2 of 2 residents

1. Resident #18 is currently residing in the Center completing usual activities of daily living. Resident #109 was discharged from the Center.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 7 reviewed for hospitalization (Residents #109 and #18). The findings included: 1. Resident #109 was admitted to the facility on 4/7/23. The admission Minimum Data Set (MDS) assessment dated 4/14/23 indicated Resident #109 was cognitively intact. Resident #109's medical record revealed he was transferred to the hospital on 4/18/23 from the cardiologist's office. There was no documentation that a written notice of transfer was provided to the resident and/or RP for the reason for transfer. Resident #109 did not return to the facility. Nurse #2 was interviewed on 6/7/23 at 2:32 PM and stated a copy of the face sheet, any Do Not Resuscitate (DNR) information, medication list, transfer form and any other pertinent documents were sent with the resident when they were transferred to the hospital. The RP would be notified by phone regarding the change and reason for the transfer. Nurse #2 stated she was unaware of a written notification of transfer being provided to the RP and/or resident. The Business Office Manager was interviewed on 6/7/23 at 2:43 PM and stated she had only been at the facility for two weeks and was unaware of a written notification of transfer being provided to the RP and/or resident. An interview occurred with the Admissions Director was interviewed on 6/7/23 at 2:46 PM.	F 623	2. An audit was completed by Director of Nursing (DON)/Designee on 6/28/2023 on residents transferred within the prior 24 hours. Any areas of needed improvement related to written notification of hospital transfer were corrected. 3. Education was provided by DON/Designee to nurses regarding written hospital transfer notification to be sent and documented on during transfer. Education was provided by Nursing Home Administrator (NHA) to Clinical Management regarding transferred resident's charts to be reviewed in Clinical Morning Meeting to ensure proper written notification is provided and documented as required. Education was provided by NHA to the Business Office to ensure a mailed copy of the written hospital transfer notice was sent to resident and/or RP and documented. Education will be completed by 7/6/2023. 4. NHA/Designee to audit the completion of written hospital transfer notification 3 times a week for 3 months. Results of the audits will be reviewed in Monthly Quality Assurance/Performance Improvement meetings and monitored ongoing as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 8	F 623		

She stated she had only been at the facility for two weeks and was unaware of a written notification of transfer being provided to the RP and/or resident.

The Social Worker was interviewed on 6/7/23 at 3:01 PM and stated she was unaware of a written notification of transfer being provided to the RP and/or resident.

The Administrator was interviewed on 6/8/23 at 11:06 AM and explained a written reason for hospital transfer was sent with the resident in the hospital discharge packet. The Administrator added there was no other written notification regarding the hospital transfer that was sent to the RP and/or resident, but they were always notified verbally. She stated she would expect the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation.

2. Resident #18 was admitted to the facility on 2/24/2023 and readmitted on 4/27/2023 with diagnoses to include femur fracture and hypertension.

The most recent significant change Minimum Data Set (MDS) assessment dated 5/2/2023 assessed Resident #18 to be severely cognitively impaired. The MDS Care Area Assessment note dated 5/2/2023 documented that Resident #18 was readmitted to the facility after hospitalization for a fractured femur that she suffered after a fall at the facility.

A review of Resident #18's electronic medical record revealed that no scanned copy of a discharge letter was in the electronic medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 9 An interview was conducted with the Admission Director on 6/7/2023 at 2:46 PM. The Admission Director reported that she had been in her position for just a couple of weeks, and she was not aware a discharge letter was required after a resident was transferred to the hospital. The Administrator was interviewed on 6/8/2023 at 1:10 PM. The Administrator reported that a letter of discharge after a resident was transferred to the hospital was an administrative process that was not clear to the Admission Director because she had been in her position for a short time.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 10 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide a written notification to the resident and the resident's representative regarding the facility's bed hold information when the residents were hospitalized for 1 of 2 residents reviewed for hospitalization (Resident #18). The findings included: Resident #18 was admitted to the facility on 2/24/2023 and readmitted on 4/27/2023. The most recent significant change Minimum Data Set (MDS) assessment dated 5/2/2023 assessed Resident #18 to be severely cognitively impaired. A review of Resident #18's electronic medical record revealed that no scanned copy of a bed hold policy was in the electronic medical record. An interview was conducted with Nurse #1 on 6/7/2023 at 9:39 AM. Nurse #1 reported he was not certain if a bed hold policy was sent with a resident when they were transferred to the hospital. Nurse #2 was interviewed on 6/7/2023 at 2:32 PM. Nurse #2 reported that a bed hold policy was not sent with a resident when they were transferred to the hospital and the admission	F 625	1. Resident #18 is currently residing in the Center completing her usual activities of daily living. 2. An audit was completed by Director of Nursing (DON)/Designee on 6/28/2023 on residents transferred within the prior 24 hours. Any areas of needed improvement related to written bed hold notification were corrected. 3. Education was provided by DON/Designee to nurses regarding written bed hold notification to be sent and documented on during transfer. Education was provided by Nursing Home Administrator (NHA) to Clinical Management regarding transferred resident's charts to be reviewed in Clinical Morning Meeting to ensure proper written notification is provided and documented as required. Education was provided by NHA to the Business Office to ensure a mailed copy of the written bed hold notification is sent to resident and/or RP and documented. Education will be completed by 7/6/2023. 4. NHA/Designee to audit the completion of written bed hold notification 3 times a week for 3 months. Results of the audits will be reviewed in Monthly Quality Assurance/Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 11 director called the resident or the resident representative to determine if they wanted their bed held during a hospital stay. An interview was conducted with the Admissions Director on 6/7/2023 at 2:46 PM. The Admissions Director reported that she had been in her position for just a couple of weeks, and as far as she knew, a bed hold policy was provided to all residents on admission to the facility, but they were not given another copy of the bed hold policy when they transferred to the hospital. The Admissions Director explained that she called the resident or the resident representative to ask if they wanted to hold the resident's bed but did not provide them with another bed hold policy. Nurse #3 was interviewed on 6/7/2023 at 3:08 PM. Nurse #3 reported she did not send a bed hold policy with a resident when they were sent to the hospital. The Administrator was interviewed on 6/8/2023 at 1:10 PM. The Administrator reported that sending the bed hold policy with a resident upon transfer to the hospital was an administrative process that was not explained clearly to the Admissions Director, who was relatively new in her position. The Administrator reported she expected the correct forms to be sent to the hospital to notify the resident and/or resident representative of the bed hold policy.	F 625	Improvement meetings and monitored ongoing as needed to ensure continued compliance.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must-	F 803		7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 12 §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide portions of food per the menu. This had the potential to affect 35 residents with diet orders for regular texture diets, and 7 residents with diet orders for pureed texture diets. The findings included: A continuous observation of the lunch meal tray line on 6/5/23 from 12:01 - 12:24 PM revealed beef stew, and pureed ravioli with pureed tomato sauce were available to serve. Review of the Daily Spreadsheet Menus recorded the following	F 803	1. On 6/7/2023 Registered Dietitian immediately educated dietary staff on proper scoop sizes per menu to ensure resident□s nutritional needs are met. 2. Registered Dietitian audited tray line for the following meal on 6/7/2023 to ensure the correct scoop size per menu was used to ensure the proper nutritional portion was provided to the residents. Any areas of needed improvement were corrected. 3. Education was provided by the Certified Dietary Manager (CDM)/Designee to the dietary staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 13 utensils were to be used for service: - Beef stew, #6 serving utensil - Pureed ravioli, #6 serving utensil - Pureed sauce, #16 serving utensil Review of the Portioning Guide revealed the following portions were to be served: - Beef stew, #6 serving utensil or 6 ounces - Pureed ravioli, #6 serving utensil or 6 ounces - Pureed sauce, #16 serving utensil or 2 ounces Cook #1 was observed to serve foods in the following portions: - Beef stew, #8 serving utensil or 4 ounces - Pureed ravioli with sauce, #8 serving utensil or 4 ounces During an interview on 6/07/23 at 3:46 PM, with the Registered Dietitian Nutritionist (RDN) Consultant present, Cook #1 stated that when she read the "spreadsheet" she knew she "was in trouble." She further stated she was concerned about having enough food, so she served smaller portions than what the menu required so that she would not run out of food. Cook #1 stated that she knew there was extra ravioli in the emergency supply that she could have served, but she thought she would get in trouble for serving two different kinds of ravioli. She further stated that she did not talk to her manager about the portions, instead she tried to do the best she could with what she had to work with. An interview with both the RDN Consultant and the Certified Dietary Manager (CDM) occurred on 6/07/23 at 2:16 PM; during the interview, the RDN Consultant stated that the portion of the beef stew and pureed ravioli with tomato sauce served should have been according to the menu. She	F 803	regarding providing portions listed per the menu using the correct scoop sizes. Education will be completed by 7/6/2023. 4. CDM/Designee to audit the proper portion sizes per the menu 3 times a week for 3 months. Results of the audits will be reviewed in Monthly Quality Assurance/Performance Improvement meetings and monitored ongoing as needed to ensure continued compliance. New hires will be educated on proper scoop sizes per menu during Department Orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 14	F 803		

stated the 4-ounce portion served was too small and did not meet the requirements for residents with diet orders for regular or pureed diets. The CDM stated he saw that Cook #1 served 4 ounces of beef stew and pureed ravioli with tomato sauce, but he did not recognize that the portions served were the wrong portions.

An interview with the Dietetic Technician Registered (DTR) occurred on 6/07/23 at 3:00 PM. The DTR stated she rounded once weekly on Mondays to complete a kitchen sanitation observation and audits. The DTR stated when she rounded, she observed refrigeration/freezer temperatures, dish machine temperatures and the meal tray line for correct portions and meal ticket accuracy. The DTR stated that occasionally she saw concerns with portions and when she identified those concerns, she provided education. The DTR stated that she did not notice on Monday, 6/5/23 that the portion of the beef stew or pureed ravioli with tomato sauce served was not large enough.

The Administrator was interviewed on 6/08/23 at 9:00 AM regarding the portions of beef stew and pureed ravioli with tomato sauce served to residents. The Administrator stated she started at the facility in April 2023, and she identified concerns in the dietary department that she took to Quality Assurance (QA) meetings, but she was not able to address everything through QA that she identified. The Administrator stated that in April 2023 the RDN Consultant and DTR conducted monthly comprehensive kitchen audits, so she asked them to start conducting weekly audits. The Administrator stated that since the weekly audits were conducted, concerns in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 15 the dietary department had improved, but additional education would be required to ensure residents received portions per the menu.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on an observation, interviews with residents and staff and record review, the facility failed to provide palatable foods to 5 of 7 sampled residents per their preferences for temperature and taste (Residents #16, #29, #62, #363, and #365). The findings included: a. Resident Council Meeting minutes documented residents expressed in the December 2022 meeting that breakfast meal trays did not have sugar or cream and that the grilled cheese sandwiches were soggy. b. A continuous observation of the lunch meal tray line on 6/5/23 from 12:01 - 12:24 PM revealed green beans were available to serve. Temperature monitoring of the green beans at 12:18 PM revealed the green beans were maintained on the steam table at 170 degrees	F 804	1. Certified Dietary Manager (CDM) interviewed residents #16, #29, #62 and #363 on 6/28/2023 regarding their food preferences. Any new preferences were updated. Resident #365 discharged from the Center. 2. Registered Dietitian audited tray line for the following meal on 6/7/2023 to ensure the residents were being provided palatable food per the menu. Any areas of needed improvement were corrected. 3. Education was provided by the Certified Dietary Manager (CDM)/Designee to the dietary staff regarding serving palatable food. Education will be completed by 7/6/2023. 4. CDM/Designee to audit for palatable food 3 times a week for 3 months. Results of the audits will be reviewed in Monthly Quality Assurance/Performance Improvement meetings and monitored	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 16 Fahrenheit (F). A review of the recipe for green beans, frozen, revealed the recipe recorded to cook the green beans according to the timetable for frozen green beans to a minimum temperature of 140 degrees F and to maintain a minimum temperature of 135 degrees F during the entire service period. The recipe recorded to season the green beans with salted margarine, salt, garlic powder, ground thyme and fresh parsley. If ground thyme was not available, a substitution of basil, dill, marjoram, oregano, rosemary, savory, or tarragon could be made. A regular diet test tray was requested on 6/05/23 at 12:24 PM. The test tray was plated, placed on an insulated plate with an insulated dome cover and placed in on an open metal cart that was covered with a plastic bag for delivery. The plastic bag was open at the bottom. The cart reached the 200 Central Hall at 12:25 PM. The test tray was the last tray tasted on the hall at 12:32 PM. The test tray included cheese ravioli with tomato sauce, green beans, garlic bread stick, iced tea and frosted cake. Margarine was provided, but there was no salt/pepper provided on the test tray. On 6/5/23 at 12:32 PM, The Certified Dietary Manager (CDM) removed the insulated dome lid and steam was visible coming from the food. Margarine was added to the cheese ravioli and green beans which required multiple attempts to stir before melting. The CDM tasted the test tray and described the food as "good and hot enough" and stated that he did not season his foods with salt or pepper. The surveyor tasted the test tray and described the food as warm, the green beans	F 804	ongoing as needed to ensure continued compliance. New hires will be educated on serving palatable food per the menu during Department Orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 17	F 804		

were bland with a mushy texture, and the ends of the garlic bread stick were hard and difficult to chew.

c. Resident #16 was admitted to the facility on 3/25/21. A quarterly Minimum Data Set (MDS) assessment dated 2/7/23, assessed Resident #16 with adequate hearing/vision, clear speech, usually able to be understood, able to understand, moderately impaired cognition, and independent with eating after assistance with tray set up. Resident #16 received a regular diet.

On 6/05/23 at 10:57 AM, Resident #16 described the food as terrible. Resident #16 stated, breakfast was good, but lunch and supper were awful; meats/vegetables were not cooked correctly, foods were cold and were not seasoned.

d. Resident #29 was admitted to the facility 4/24/23. An admission MDS assessment dated 4/26/23, assessed Resident #29 with adequate hearing/vision, clear speech, usually able to be understood, able to understand, intact cognition, and independent with eating after assistance with tray set up. Resident #29 received a carbohydrate-controlled diet.

On 6/05/23 at 11:36 AM, Resident #29, stated the food was cold especially the coffee and eggs, "like they have just come out of fridge", and that she often received greasy bacon. During an interview on 6/7/23 at 10:00 AM, Resident #29 stated that most of the time her food was lukewarm when she received it, but the facility always served cold eggs and they "need to have some type of insulated bowl to put them in."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 18	F 804		

e. Resident #363 was admitted to the facility on 5/20/23. An admission MDS assessment dated 5/27/23, assessed Resident #363 with adequate vision/hearing, clear speech, able to understand and be understood, moderately impaired cognition, and independent with eating after assistance with tray set up. Resident #363 received a carbohydrate controlled, no added salt diet.

On 6/05/23 at 1:02 PM, Resident #363 was observed with her lunch meal and stated she did not like the ravioli, but she ate half of it and ate some of the green beans, but they were too soft. She stated the food was hot sometimes, but that the eggs and grits served at breakfast were always cold.

f. Resident #62 was admitted to the facility on 12/7/22. A quarterly MDS assessment dated 3/16/23 assessed Resident #62 with adequate hearing/vision, clear speech, able to understand and be understood, moderately impaired cognition, and totally dependent on staff for assistance with his meals. Resident #62 received a carbohydrate-controlled diet.

On 6/05/23 at 1:17 PM, Resident #62 was observed with his lunch meal tray in his room. He stated that he did not really like the food served, he stated he ate the ravioli, it was warm, but it would have been better if it were hotter. He stated he asked staff to reheat his food in the past, but they did not so he stopped asking.

g. Resident #365 was admitted to the facility on 5/26/23. An admission MDS assessment dated 6/2/23 assessed Resident #365 with adequate hearing/vision with corrective lenses, clear

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 19	F 804		

speech, able to understand and be understood, intact cognition, and required supervision with meals after assistance with tray set up. Resident #365 received a regular diet.

On 06/06/23 at 11:07 AM, Resident #365 stated the food lacked seasoning, and explained "it's like they have an aversion to using any kind of salt."

Cook #1 stated in an interview on 6/07/23 at 11:45 AM that she cooked the green beans in the steamer and added chicken base, pepper and garlic and did not notice the additional seasonings on the recipe.

During an interview with the CDM on 6/5/23 at 12:35 PM, he stated that he did not conduct test tray audits as often as he would like to, but the Registered Dietitian Nutritionist (RDN) Consultant and the Dietetic Technician Registered (DTR) conducted test tray audits quarterly and there were occasional comments about temperature and taste, but usually the test tray audits obtained good results. The CDM stated he reviewed Resident Council Minutes for comments about the food and that he was aware of previous comments about condiments not available on the meal trays, but that the residents were usually complimentary.

The RDN Consultant was interviewed on 6/07/23 at 2:50 PM and stated she conducted a meal satisfaction evaluation with residents and test tray audits three times per year. The meal satisfaction evaluation was based on resident opinion of the food at the point of service with an expectation of the hot foods to reach residents above 120 degrees Fahrenheit (F) and the cold food to be at least 50 degrees F. The RDN Consultant stated a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 20	F 804		

minimum of 11 residents were asked questions and the responses were shared with the CDM. Questions included were the hot food hot/warm enough, cold food cold enough, does it taste good, do you receive your choices/alternate items as requested, and does the food look appetizing/attractive? The RDN Consultant stated the most recent score was 79 in March 2023. The RDN Consultant stated concerns identified from the meal satisfaction evaluation and the test tray audits were regarding food temperature concerns, menu changes to meet food preferences, and receiving meals timely.

An interview with the DTR occurred on 6/07/23 at 3:00 PM. The DTR stated she rounded once weekly on Mondays to complete a kitchen sanitation observation and audits. The DTR stated she conducted meal satisfaction evaluations and test tray audits occasionally and the last test tray audit she completed was in December 2022. The DTR stated at the time there were a few comments about taste/temperature, foods not being hot enough, but that most of the comments were about preferences not being honored.

The Administrator was interviewed on 6/08/23 at 9:00 AM regarding the palatability of food served to residents. The Administrator stated she started at the facility in April 2023, and she identified concerns in the dietary department that she took to Quality Assurance (QA) meetings, but she was not able to address everything through QA that she identified. The Administrator stated that in April 2023 the RDN and DTR conducted monthly comprehensive kitchen audits, so she asked them to start conducting weekly audits. The Administrator stated that since the weekly audits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 21 were conducted, concerns in the dietary department had improved, but additional education would be required to ensure residents received palatable foods. During an interview on 6/8/23 at 1:20 PM with the Director of Nursing (DON), she stated she was aware that residents expressed concerns during meal satisfaction evaluations regarding receiving cold foods, as a result, nursing staff were educated to support meal service with "all hands-on deck" to get trays out as quickly as possible. The DON stated that she expected nursing staff to reheat food if a resident expressed that their food was not hot enough for them. The DON stated it came to her attention that some nursing staff did not reheat food for residents, stating that the microwave was too far away and by the time the food was reheated and returned to the resident, the food was cold again or another resident may have the same complaint and "so what's the point?" The DON stated continued education was required.	F 804		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide cheese ravioli with sauce according to the recipe to residents with diet orders for soft and bite sized foods. This failure	F 805	1. On 6/7/2023 Registered Dietitian immediately educated dietary staff on following recipes as it relates to soft and bite sized diets. 2. Registered Dietitian audited tray line	7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 22	F 805		

had the potential to affect 16 of 111 residents with diet orders for soft and bite sized foods.

The findings included:

A review of the facility product order sheet revealed the facility ordered and received 3 cases of ravioli described as "Pasta, Ravioli, 4 Cheese, Jumbo, Round, Frozen" for the lunch meal served on 6/5/23.

A review of the Resident Diet Information report revealed 16 residents with diet orders for soft and bite-sized foods.

The recipe for cheese ravioli with sauce recorded residents with diet orders for soft and bite-sized, "must receive food pieces with food particle size no greater than ½ inch by ½ inch" and if foods could not be served per this description, to "serve a minced and moist diet with a particle size no greater than 1/8 inch by ½ inch" or serve a pureed diet.

A continuous observation of the lunch meal tray line on 6/5/23 from 12:01 - 12:24 PM revealed jumbo ravioli with pureed tomato sauce was served to residents with diet orders for a soft and bite-sized diet.

During an interview on 6/07/23 at 3:46 PM, with the Registered Dietitian Nutritionist (RDN) Consultant present, Cook #1 stated that the ravioli served for lunch on 6/5/23 to residents with diet orders for soft and bite sized diets was "huge, like the size of frisbees." Cook #1 stated she did not discuss the size of the ravioli with her manager but stated that "we sometimes get the jumbo ravioli, and we sometimes get the regular

for the following meal on 6/7/2023 to ensure recipes were being followed as it related to soft and bite sized diets. Any areas of needed improvement were corrected.

3. Education was provided by the Certified Dietary Manager (CDM)/Designee to the dietary staff regarding serving meals compliant with diet orders for soft and bite sized foods. Education will be completed by 7/6/2023.

4. CDM/Designee to audit for compliance related to soft and bite sized foods 3 times a week for 3 months. Results of the audits will be reviewed in Monthly Quality Assurance/Performance Improvement meetings and monitored ongoing as needed to ensure continued compliance. New hires will be educated on serving meals compliant with diet orders for soft and bite sized foods during Department Orientation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 23	F 805		

sized, which would be more like bite sized, so I just work with what we get."

During an interview with the Speech Therapist (ST) on 6/07/23 at 11:21 AM, she stated that residents with diet orders for soft and bite sized foods should receive all foods per their diet order. The ST stated that she observed the ravioli served at lunch on 6/5/23 and the ravioli that was served did not meet the size requirements for a bite sized food. The ST stated she assisted a resident during lunch on 6/5/23 with a diet order for soft and bite sized foods and the ST had to cut up the ravioli into bite sized pieces. The ST further stated that residents should receive the level of assistance necessary with meals to ensure they either receive bite sized foods or that foods are cut up into bite sized pieces for the resident. The ST stated in the past when she observed foods were not bite sized, she usually informed dietary staff, but she did not know why she did not report this observation to dietary on 6/5/23.

An interview with both the RDN Consultant and the Certified Dietary Manager (CDM) occurred on 6/07/23 at 2:16 PM. During the interview, the CDM stated that he ordered the jumbo ravioli in error. He stated that each one-ounce ravioli was not bite sized and larger than a ½ inch by ½ inch portion as the recipe required. The RDN Consultant stated that residents on a soft and bite sized diet received the soft portion of the diet order but did not receive the correct size ravioli to meet the bite sized requirement of the diet order.

An interview with the Dietetic Technician Registered (DTR) occurred on 6/07/23 at 3:00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 24	F 805		

PM. The DTR stated she rounded once weekly on Mondays to complete a kitchen sanitation observation and audits. The DTR stated when she rounded, she observed refrigeration/freezer temperatures, dish machine temperatures and the meal tray line for correct portions and meal ticket accuracy. The DTR stated that occasionally she saw concerns with portions and when she identified those concerns, she provided education. The DTR stated that she did not notice on Monday, 6/5/23 that the size of the ravioli served to residents at lunch with diet orders for soft and bite sized was not the correct size.

The Administrator was interviewed on 6/08/23 at 9:00 AM regarding the ravioli served to residents with soft and bite sized diet orders. The Administrator stated she started at the facility in April 2023, and she identified concerns in the dietary department that she took to Quality Assurance (QA) meetings, but she was not able to address everything through QA that she identified. The Administrator stated that in April 2023 the RDN and DTR conducted monthly comprehensive kitchen audits, so she asked them to start conducting weekly audits. The Administrator stated that since the weekly audits were conducted, concerns in the dietary department had improved, but additional education would be required to ensure residents on a soft and bite sized diets received foods according to the bite sized portion of the diet as well. The Administrator stated that the soft and bite sized diet should come from the kitchen as appropriate so that nursing did not have to cut up food for residents. She stated her team would look at how to correct that in dietary going forward.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		7/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 26 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident, and staff interviews, the facility failed to document refusals to wear compression hose for 1 of 3 residents investigated for non-pressure related skin issues (Resident #24). The findings included: Resident #24 was admitted to the facility on 6/30/2021 with diagnoses to include unspecified lymphedema (swelling of an extremity caused by	F 842	1. Resident #24 currently resides in the Center completing usual activities of daily living. Resident #24 TED hose order was discontinued on 6/27/2023 after Inter Disciplinary Team review. 2. An audit was completed by Director of Nursing (DON)/Designee on 6/17/2023 of in-house residents with physician's orders for the application of TED hose. 5 residents with TED hose audited for documentation accuracy with no issues	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 27 accumulation of fluid) and hypertension. A physician order for Resident #24 dated 1/10/2023 ordered to apply compression hose in the morning and remove the hose at night. The most recent Quarterly Minimum Data Set (MDS) assessment dated 5/5/2023 assessed Resident #24 to be severely cognitively impaired. The MDS assessed Resident #24 to require supervision of one person for dressing. The MDS documented Resident #24 did not refuse care. A review of the medication administration record for June 2023 revealed that compression hose was documented as applied on 6/5/2023 by Nurse #4 and 6/7/2023 by Nurse #1. It was documented on the medication administration record that Nurse #3 removed Resident #24's compression hose on 6/6/2023 in the evening. Resident #24 was observed on 6/5/2023 at 12:15 PM. Resident #24 was sitting on the side of the bed with her legs dangling. Both legs appeared swollen and Resident #24 was not wearing compression hose. When asked about her legs, Resident #24 stated, "Yes, they are very swollen today." An observation of Resident #24 was conducted on 6/7/2023 at 9:07 AM. Resident #24 was sitting up in a chair wearing a dress. Her lower legs were swollen, and she did not have compression hose on her legs. Resident #24 stated, "I never wear any kind of hose," when asked about the compression hose. Nursing assistant (NA) #1 was interviewed on 6/7/2023 at 9:13 AM. NA #1 reported that	F 842	found. 3. Education was provided by DON/Designee to nurses regarding the completion of accurate documentation. Education will be completed by 7/6/2023. 4. DON/Designee to audit documentation accuracy through observations and Treatment Administration Record review 3 times a week for 3 months to ensure physician orders are being followed as prescribed. Results of the audits will be reviewed in Monthly Quality Assurance/Performance Improvement meetings and monitored ongoing as needed to ensure continued compliance. New hires will be educated on the completion of accurate documentation during Department Orientation. DON responsible for Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 28	F 842		

Resident #24 was able to dress herself without assistance and she refused staff help most of the time. NA #1 reported Resident #24 did not wear compression hose.
An interview was conducted with NA #2 on 6/7/2023 at 9:39 AM. NA #2 reported that Resident #24 would not allow staff to assist her to dress, and she did not wear compression hose.

Nurse #1 was interviewed on 6/7/2023 at 9:39 AM. Nurse #1 was asked to review the medication administration record and he noted that Resident #24 had orders to apply compression hose every morning. When asked why he documented that Resident #24 had compression hose applied on 6/7/2023, he reported he was not certain why he documented because he had not applied the compression hose.

The Nurse Practitioner (NP) was interviewed on 6/7/2023 at 12:29 PM. The NP reported he was not aware that Resident #24 refused to wear compression hose. The NP explained if he was aware Resident #24 would not wear compression hose, he could have changed the orders to better accommodate her.

Nurse #3 was interviewed on 6/7/2023 at 3:08 AM. Nurse #3 reported she worked the afternoon shift from 3:00 PM to 11:00 PM. Nurse #3 was asked about her documentation that she removed Resident #24's compression hose in the evening. Nurse #3 reported that she had not removed the compression hose but had documented that Resident #24 was not wearing compression hose at bedtime.

Nurse #4 was interviewed by phone on 6/7/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 29 at 3:48 PM. Nurse #4 reported that she had documented that she put the compression hose on for Resident #24 on 6/5/2023, but she did not apply the hose. Nurse #4 reported she had not notified the physician or NP that the resident was refusing. Nurse #4 reported that "sometimes" she documented that Resident #24 refused to have the compression hose applied.	F 842		