STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. BUILDING _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 11/27/23 through 11/30/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XIQS11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/27/23 through 11/30/23. Event ID# XIQS11. The following intakes were investigated NC00205596, NC00207362, NC00207856, NC00209049 and NC00209595. Five of the 16 complaint allegations resulted in deficiency.	F 000		
F 582 SS=F	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		12/28/23

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

Electronically Signed | 12/21/2023

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F 582	Continued From page 1 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of non-coverage (SNF ABN) by omitting the estimated out of pocket cost for care for 3 of 3	F 582	F 582 Medicaid/Medicare Coverage Liability A new Advanced Beneficiary Notice of non-coverage (ABN)/ liability notice was	

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F 582	Continued From page 2 residents reviewed for beneficiary notices (Residents #70, #134, #393). Findings included: a. Resident #70 was admitted to the facility on 9/26/23. Review of Resident #70's record indicated the SNF ABN dated 11/8/23 had no estimated out of pocket cost for care documented on the form. Resident #70 remained in the facility with benefit days remaining. b. Resident #134 was admitted to the facility on 10/19/23. Review of Resident #134's record indicated the SNF ABN dated 11/22/23 had no estimated out of pocket cost for care documented on the form. Resident #134 remained in the facility with benefit days remaining. c. Resident #393 was admitted to the facility on 11/9/23. Review of Resident #393's record indicated the SNF ABN dated 11/21/23 had no estimated out of pocket cost for care documented on the form. Resident #393 remained in the facility with benefit days remaining. During an interview with Social Worker #1 on 11/30/23 at 3:00 PM, she indicated she had been in her position for 11 years and had never been made aware the estimated out of pocket cost for care needed to be on the SNF ABN. She further stated the SNF ABN came prefilled from the corporate office. She indicated that the Social	F 582	given to Resident # 70 on 12-19-23 by the Social Worker containing estimated costs of all out-of-pocket services. The Administrator validated this on 12-19-23. A new Advanced Beneficiary Notice of non-coverage (ABN)/ liability notice was given to Resident #134 on 12-19-23 by the Social Worker containing estimated costs of all out-of-pocket services. The Administrator validated this on 12-19-23. A new Advanced Beneficiary Notice of non-coverage (ABN)/ liability notice was given to Resident #393 on 12-19-23 by the Social Worker containing estimated costs of all out-of-pocket services. The Administrator validated this on 12-19-23. On 12-19-23, an audit of all Medicare A discharges for the past 30 days was completed by the Business Office Manager to ensure all Notifications of Medical Non-Coverage (NOMNC) were completed appropriately to include providing estimated out of pocket costs for all services. All areas of concern were addressed by Business Office Manager to include issuing appropriate notification of non-coverage with estimated costs of all services provided to the resident/resident representative. On 12-19-23 an in-service was initiated by the Administrator with the Accounts Receivable and Social Workers regarding Notifications of Medical Non-Coverage (NOMNC) with emphasis on providing appropriate notification related to non-coverage of Medicare A residents to include providing an estimated out of pocket cost of all services. The in-service will be completed by 12-21-23. All newly	

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F 582	Continued From page 3 Work office was the only one to distribute the SNF ABN to Residents. An interview with Social Worker #2 on 11/30/23 at 3:00 PM revealed she also was unaware the estimated out of pocket cost for care needed to be included on the SNF ABN. She further stated that Social Work was the only office to distribute the SNF ABN to Residents and that they came prefilled from the facility Corporate Office. During an interview with the Administrator on 11/30/23 at 1:30 PM, she indicated she was unaware that the estimated out of pocket cost or care was to be included on the SNF ABN and that she would have the forms updated going forward.	F 582	hired Administrators, Accounts Receivable Bookkeepers, and/or Social Workers will be in-serviced during orientation regarding Notifications of Medical Non-Coverage (NOMNC). A 10% audit of all Medicare A discharges will be reviewed by the Business Office Manager weekly x 4 weeks then monthly x 1 month utilizing the NOMNC Form Audit tool to ensure the appropriate notification of medical non-coverage to include an estimated cost of all services was provided to the resident/resident representative with the appropriate box checked and signature. The Social Worker and/or Accounts Receivable staff will address all areas of concern identified during the audit. The Staff Facilitator will re-educate staff for any concerns identified. The Administrator will review the NOMNC Form Audit tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the NOMNC Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months. The QAPI Committee will meet monthly x 2 months and review the NOMNC Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		12/28/23

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F 584	Continued From page 4	F 584		

The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

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F 584	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview the facility failed to maintain walls and resident beds in good repair for 6 of 6 resident rooms (Room # 104, 105, 106, 111, 301 and 602) reviewed for provision of a safe, clean, homelike environment. The findings included: A. Room #104 bed A was observed on 11/27/23 at 11:32 AM. During the observation it was revealed the footboard was completely disconnected from the bed. It was resting perpendicular on the frame of the bed which could cause injury to the resident if it fell onto the Resident's feet while in bed. A second observation of Room #104 bed A was made on 11/30/23 at 12:30 PM with the Maintenance Director. The observation revealed the footboard of bed A was completely disconnected and resting on the frame. Room #104 bed B was observed on 11/27/23 at 11:32 AM. During the observation it was revealed the Resident's headboard was damaged in one corner. The corner piece was being held on by clear office tape. The Resident in room #104 bed B stated she had asked for her headboard to be repaired or replaced a couple of months ago and had not received a response. She stated she had put the broken piece back on with strips of clear office tape in the meantime. A second observation of Room #104 bed B was made on 11/30/23 at 12:30 PM with the	F 584	F 584 Safe/Clean/Comfortable/Homelike Environment On 12-19-23, the footboard in Room 104-A was re-attached to the bedframe by the Maintenance Director and verified by administrator observation. On 12-19-23, the headboard was replaced in Room 104-B by the Maintenance Director and verified by administrator observation. On 12-19-23, the drywall in Room 105-A was repaired by the Maintenance Director and verified by administrator observation. On 12-19-23, the drywall in Room 106-A was repaired by the Maintenance Director and verified by administrator observation. On 12-19-23, the drywall was repaired in Room 111-B by the Maintenance Director and verified by administrator observation. On 12-19-23, the drywall was repaired in Room 301 by the Maintenance Director and verified by administrator observation. On 12-19-23, the drywall was repaired in Room 602 and the headboard was fully re-attached to bed by the Maintenance Director and verified by administrator observation. On 12-1-23, the Maintenance Director under the oversight of the Administrator initiated an audit of all resident rooms to include rooms 104, 105, 106, 111, 301, and 602. This audit was completed to identify any room that needs repair to include, but not limited to, damaged walls, broken headboard, and broken footboard to maintain a safe and homelike environment. The Administrator will	

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F 584	Continued From page 6 Maintenance Director. The observation revealed a piece of broken headboard being held on by clear office tape. B. An observation of Room #105 bed A on 11/27/23 at 12:30 PM revealed damage to the wall at the head of the bed where wallpaper was torn away and there were deep scratches with drywall visible. A second observation of Room #105 bed A on 11/30/23 at 9:10AM revealed no change in the damage to the wall at the head of the bed where the wallpaper was torn away and there were deep scratches with drywall visible. C. An observation of Room #106 bed A on 11/27/23 at 12:34 PM revealed wallpaper missing and peeling along the wall at the side of the bed. Drywall was visible with scratches approximately 3 feet long and 3 inches wide. A second observation of Room #106 bed A on 11/30/23 at 9:15 AM revealed the damaged wall to be unchanged, with missing and peeling wallpaper and visible scratches. D. An observation of Room #111 bed B on 11/27/23 at 12:40 PM revealed peeling and missing wallpaper and gouges in drywall behind the bed as well as a large area of missing wallpaper and scratched drywall under the window. A second observation of Room #111 bed B on 11/30/23 at 9:20 AM revealed there was no change in the condition of the damaged walls with peeling and missing wallpaper and scratched drywall.	F 584	address all concerns identified during the audit to include, but not limited to, repairing damaged walls, painting or replacement of wallpaper when indicated, and/or repair/replace damaged headboards and footboards. The audit will be completed by 12/28/23. The Maintenance will provide the Administrator a schedule for completion of all areas of concern identified. On 12-1-23, the Administrator completed an in-service with the Maintenance Director and maintenance staff regarding Maintaining a Safe and Homelike Environment with emphasis on timely repair of facility and resident rooms to maintain a safe and homelike environment and not resolving work orders in TELs system until repairs are completed. On 12-1-23, the Staff Development Coordinator (SDC) initiated an in-service with all nurses, nursing assistants, therapy staff, housekeeping staff, maintenance staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director regarding Safe and Homelike Environment. Emphasis placed on the process for prompt reporting of any area in the facility in need of repair to maintain a safe and homelike environment to include but not limited to peeling wallpaper/paint, damaged or unattached headboards/footboards, and damaged drywall in resident rooms. The in-service will be completed by 12-28-23. After 12-28-23, any staff who has not received the training will complete the	

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F 584	Continued From page 7 E. An observation of Room #301 (private room) on 11/27/23 at 12:10 PM revealed a circular area measuring about 1 x 1 foot where the wallpaper was scratched off and the drywall was deeply gouged. The Resident in room #301 stated on 11/27/23 at 12:10 PM the deep gouge in the wall to the right of her bed had been there for at least a year. She indicated she had asked staff about having it fixed and stated she had received no response. A second observation of room #301 on 11/30/23 at 9:40 AM revealed no change in damage to wall to the right of the bed. There continued to be missing wallpaper and gouged drywall. In an interview with Nurses Aide #1 on 11/30/23 at 10:00 AM it was revealed all maintenance work orders were to be entered into the facility maintenance request system. She further stated any employee could put in a request. An interview with Nurse #1 on 11/30/23 at 10:08 AM revealed she put all maintenance work orders into the facility maintenance request system. She further stated she would enter requests such as televisions not working, water leaks or beds not working properly. An interview with the Unit Manager on 11/30/23 at 10:20 AM revealed staff would put maintenance requests into the facility maintenance request system. The Unit Manager stated that there used to be 3 maintenance staff, but they had lost one sometime in the last 6 months. An interview with the Maintenance Manager on	F 584	in-service on the next scheduled work shift. All newly hired nurses, nursing assistants, therapy staff, housekeeping staff, maintenance staff, accounts payable, accounts receivable, social worker, administrator, activity staff, receptionist, scheduler, and medical records director will be in-serviced during orientation regarding Maintaining a Safe and Homelike Environment. The Administrator will complete facility rounds to include all resident rooms twice a week x 4 weeks then monthly x 1 month utilizing the Environmental Rounds Audit Tool. This audit is to identify any area in the facility in need of repair to include but not limited to damaged walls, damaged or unattached headboards/footboards, and/or areas in need of painting to maintain a safe and homelike environment. Staff that identify an area of concern will place work order in TELS which will notify the maintenance director and/or assistant medical director for all identified areas of concern and notify the Maintenance Director. The Maintenance Director will address all work orders submitted for concerns identified to include but not limited to repairing, painting walls, replacing drywall, and/or replacing broken or unattached headboards and footboards. The Administrator will review the Environmental Rounds Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will present the findings of the Environmental Rounds Audit Tool to	

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F 584	Continued From page 8 11/30/23 at 12:30 PM revealed he received maintenance requests through the maintenance request system, and it appeared on his phone in real time. Maintenance does not inspect rooms for issues, they rely on the request system. He further stated he was aware of the condition of the walls in some rooms. The maintenance staff they lost recently was the one who fixed the walls. He further stated they were not currently looking for a third maintenance staff person until the building census increased. In an interview with the Director of Nursing on 11/30/23 at 11:08 AM she indicated that all maintenance work requests would be entered into the facility maintenance request system by any staff member. She further stated that the facility lost a maintenance worker about 3 months ago. She was unaware if the facility was trying to replace him. F. Room 602 was observed on 11-27-23 at 11:59am. The observation revealed 4 linear indented lines on the wall behind the resident's bed that revealed plaster. The resident's headboard to his bed was also observed to only be attached on one side allowing the headboard to hang and move freely which could cause injury to the resident if he tried to hold onto the headboard while moving in bed. A second observation occurred on 11-29-23 at 8:53am with the Maintenance Director. The observation revealed 4 linear indented lines on the wall behind the resident's bed that revealed plaster and the resident's headboard to his bed was also observed to only be attached on one side. The Maintenance Director was interviewed on	F 584	the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Environmental Rounds Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 584	Continued From page 9 11-29-23 at 8:55am. The Maintenance Director discussed the damage to room 602's wall and stated he was aware the wall needed repair. He explained the maintenance department was short handed and they were trying to repair the walls when they had a chance. When the Maintenance Director examined the resident's headboard on his bed, he stated the headboard had lost a screw. He said he was not aware of the loose headboard and explained staff would report maintenance issues in their computer system and did not know why the staff had not reported the resident's headboard being loose. The Administrator was interviewed on 11-29-23 at 2:40pm. The Administrator discussed the maintenance department being short-staffed and confirmed staff requested maintenance repairs through their computer system. She stated she was aware of the need for repairs to the resident's wall but was unaware of the loose headboard. The Administrator discussed the loose headboard could cause injury to the resident if he attempted to grab the headboard while repositioning in the bed.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to perform incontinence care on 1 of 1 resident (Resident #24) who was dependent on staff for incontinence	F 677	F 677 ADL Care Provided for Dependent Residents On 11-29-23, the Director of Nursing assessed Resident #24 to ensure	12/28/23

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F 677	Continued From page 10 care, in a manner to prevent the likelihood of an infection. Resident #24 was observed for Activities of Daily Living (ADL) care. Findings included: Resident #24 was admitted to the facility on 6-11-21 with multiple diagnoses that included dementia. The quarterly Minimum Data Set (MDS) dated 11-9-23 revealed Resident #24 was severely cognitively impaired and required extensive assistance with one person for toileting, bed mobility and personal hygiene. Resident #24's care plan dated 11-21-23 revealed Resident #24 had urinary incontinence related to cognitive impairment. The goal for Resident #24 included to be free of infection and skin breakdown. The interventions for the goal were to encourage good hygiene and receive peri care after each incontinent episode. Observation of ADL care occurred on 11-29-23 at 9:09am with Nursing Assistant (NA) #1. Resident #24's skin was observed to be intact with no redness. NA #1 was observed cleaning Resident #24's peri area. The NA cleaned Resident #24's peri area from back to front two times. During an interview with NA #1 on 11-29-23 at 9:30am, the NA discussed having to ask another NA on the proper way of cleaning a woman's peri area "because I could not remember, and they told me to clean back to front." NA #1 also stated he thought if he cleaned the peri area from front to back, he would cause bacteria to enter the vaginal cavity.	F 677	incontinent care had been provided in a manner to prevent the likelihood of an infection. There were no concerns identified. On 11-29-23, NA #1 was educated regarding correct technique with incontinent care to include wiping front to back to prevent infection. A successful return demonstration during resident care was completed by NA #1 as observed and validated by the Director of Nursing. On 11-29-23, the Staff Development Coordinator initiated an audit of all nursing assistants to ensure residents were provided incontinent care using the correct technique, wiping front to back, to prevent the likelihood of an infection. The Staff Development Coordinator will address all concerns identified during the audit to include providing incontinent care using the correct technique of wiping front to back and education of the staff. The audit will be completed by 12-28-23. On 11-29-23, the Director of Nursing initiated an in-service with all and nursing assistants regarding Incontinent Care including using correct technique to prevent the likelihood of infection. The in-service will be completed by 12-28-23. After 12-28-23, any nursing assistant who has not worked or received the in-service will complete upon next scheduled work shift. All newly hired nursing assistants will be in-serviced during orientation by the Staff Development Coordinator (SDC) regarding Incontinent Care to include a successful return demonstration of correct incontinence care technique. The Unit Managers will complete 15	

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F 677	Continued From page 11 The Staff Development Coordinator (SDC) was interviewed on 11-29-23 at 9:49am. The SDC explained when a new NA was hired, the NA would spend two days in the classroom discussing incontinence care and then the NA would be checked off on the skill of incontinence care by their preceptor. She also explained that staff performed random audits on the NAs to ensure proper technique was being used when cleaning a woman's peri area. The SDC stated NA #1 had received education on incontinence care and did not know why he would have used a back to front cleaning technique on Resident #24. An interview with the Director of Nursing (DON) was conducted on 11-29-23 at 2:13pm. The DON discussed NA #1 being nervous during the observation but stated she would have expected the NA to clean Resident #24's peri area from front to back. The Administrator was interviewed on 11-29-23 at 2:30pm. The Administrator stated she believed NA #1 was nervous during the observation and knew how to clean a woman's peri area correctly. She said she expected residents to be cleaned from front to back during incontinence care.	F 677	Resident Care Incontinent Audits on residents who are incontinent to include Resident #24 weekly x 4 weeks, then monthly x 1 month. Audits will include all shifts and all days of the week. This audit is to ensure all residents with incontinence are provided incontinent care timely. The Unit Managers will address all concerns identified during the audit to include providing incontinent care when indicated and re-education of the staff. The Director of Nursing will review the Resident Care Incontinent Audits weekly x 4 weeks, then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will present the findings of the Resident Care Incontinent Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Resident Care Incontinent Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		12/28/23

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F 688	Continued From page 12 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to place palm guards on the left and right hands for 1 of 1 resident (Resident #3) reviewed for range of motion. Findings included: Resident #3 was admitted to the facility on 5-31-12 with multiple diagnoses that included right hand contracture. The quarterly Minimum Data Set (MDS) dated 9-20-23 revealed Resident #3 was severely cognitively impaired. Resident #3's care plan dated 10-6-23 did not have any goals or interventions for palm guards. An observation of Resident #3 occurred on 11-27-23 at 11:20am. Resident #3's right and left hand were observed to be contracted with no palm guards present. Another observation of Resident #3 occurred on 11-28-23 at 4:00pm. The observation revealed there were no palm guards placed on the resident's left or right hand.	F 688	F 688 Increase/Decrease in ROM/Mobility On 11/30/23, Resident #3 was evaluated by Occupational Therapy for bilateral hand contractures and use of palm guards. On 12/7/23, the Unit Managers completed an audit of all residents in the facility to assess for contractures. This audit was completed to ensure any resident identified with one or more contractures had interventions in place to prevent further decrease in range of motion to include palm guards, splints, and/or therapy recommendations as appropriate. No further concerns were identified. On 12/7/23, the Staff Development Coordinator initiated an audit of all Nursing Functional Maintenance Program referrals for the past 30 days to treat contractures. This audit is to ensure care plans are updated for contracture interventions including palm guards and	

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F 688	Continued From page 13 Resident #3 was observed on 11-29-23 at 8:15am. Resident #3 was observed laying in the bed without palm guards to her left or right hand. During an interview with Nursing Assistant (NA) #2 on 11-29-23 at 8:42am, the NA discussed being familiar with Resident #3 and being aware the resident had contractures to her left and right hands. She explained Resident #3 had braces and palm guards "about 2 years ago" and stated for the past "few months" Resident #3 had not had any braces or palm guards to her left and right hands. Nurse #1 was interviewed on 11-29-23 at 8:46am. The nurse discussed being familiar with Resident #3 and stated the resident "used to" have palm guards to her left and right hands. Nurse #1 explained she did not know why Resident #3 no longer had the palm guards. She said she tried to remember to remind the NAs to place a rolled washcloth in Resident #3's hand to prevent her fingernails cutting into the palms of her hands. The Rehab Director was interviewed on 11-29-23 at 10:14am. The Rehab Director explained Resident #3 had last received services in September 2022. She further explained Resident #3 was to receive restorative services to continue working on the resident's bilateral hand contractures. The Rehab Director stated at the end of Resident #3's rehab services, the resident was ordered bilateral palm guards. She discussed the restorative program switching to a functional maintenance program "around" January 2023 but stated Resident #3 should have continued with services. The Rehab Director said Resident #3 had "fallen through the cracks."	F 688	splint/contracture devices are worn as ordered/recommended by therapy. On 12/18/23, the Staff Development Coordinator in-serviced certified nursing assistants and minimum data set nurses are responsible for carrying out the program regarding the referral process for the Nursing Functional Maintenance Program to include ensuring care plans are updated for contracture interventions including palm guards and splint/ contracture devices are worn as ordered/recommended by therapy. The in-service will be completed by 12/28/23. All newly hired certified nursing assistants and minimum data set nurses will receive training during orientation by the Staff Development Coordinator (SDC). On 12/18/23, an in-service was initiated by the Staff Development Coordinator (SDC) for all nurses and nursing assistants on “Observation and Reporting of Contractures during Resident Care: any resident observed with contractures that does not have a splint, palm guard, or intervention in place must be reported immediately to the supervisor and/or the Director of Nursing (DON).” The in-service will be completed by 12-28-23. After 12-28-23, any staff member that has not received the in-service will be educated prior to the next scheduled shift. All newly hired nurses and nursing assistants will receive the in-service during orientation by the Staff Development Coordinator (SDC). All Nursing Functional Maintenance	

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F 688	Continued From page 14 An interview with the Staff Development Coordinator (SDC) occurred on 11-29-23 at 11:02am. The SDC confirmed she was responsible for coordinating the residents from the restorative program to the functional maintenance program. The SDC explained when the restorative program was changed to the functional maintenance program, Resident #3 should have been referred to therapy for an evaluation. She further explained the MDS nurses were responsible for making the referral to the therapy department. During an interview with MDS Nurse #1 on 11-29-23 at 11:16am, the MDS Nurse explained that she had never received an order to place Resident #3 on the restorative program back in September 2022, so she was unaware Resident #3 needed a referral to therapy when the program changed to the functional maintenance program. The Director of Nursing (DON) was interviewed on 11-29-23 at 2:02pm. The DON discussed the restorative program changing to the functional maintenance program but stated she did not know when that occurred. She discussed managers and department heads having a meeting each morning and talking about what residents were being released from therapy and if the resident would be placed on the functional maintenance program. The DON stated she could not remember if Resident #3 had been discussed and was unaware Resident #3 had not been receiving services. During an interview with the Administrator on 11-29-23 at 2:25pm, the Administrator discussed meeting each morning with management and the	F 688	Program referrals will be monitored by the Staff Development Coordinator 5 times weekly x 4 weeks, then once weekly x 1 month utilizing the Functional Maintenance Referral Monitoring tool. This monitoring audit will be completed to ensure all referrals to the Nursing Functional Maintenance Program are completed with care plans updated for contracture interventions including palm guards and splint/contracture devices are worn as ordered/recommended by therapy. Any concerns identified during the audit will be addressed immediately by the Staff Development Coordinator to include providing additional training as needed. The DON will review the Functional Maintenance Referral Monitoring tool weekly x 4 weeks, then monthly x 1 month for completion. The DON will present the findings of the Functional Maintenance Referral Monitoring tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Smoking Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 688	Continued From page 15 department heads to talk about the residents being released from therapy and if the resident would need to follow the functional maintenance program. She stated she was unaware Resident #3 had no longer been receiving services and would have expected Resident #3 to receive services through the functional maintenance program and had her bilateral palm guards placed per therapies recommendations.	F 688		
F 689 SS=E	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: Based on observation, record review, and resident and staff interviews, the facility failed to ensure that smoking materials were secured by staff for three of three sampled residents observed for accidents (Resident #101, Resident #107, and Resident #119). Findings included: The facilities smoking policy dated 2019 stated all resident smoking materials were maintained in a secured area and were accessible only through the assistance of the facility staff. Assessment of Residents ability to smoke in a safe manner would occur prior to smoking in designated outdoor areas. Safe smokers would be	F 689	F 689 Free of Accident Hazards/Supervision/Devices On 12/18/23, Resident #101 was educated by the administrator regarding 1) Storage of Smoking Materials (2) Designated Outside Smoking Areas/times (3) Policy Violations with all residents that smoke. All smoke materials were removed and secured per facility protocol. On 12/18/23, Resident #107 was educated by the administrator regarding 1) Storage of Smoking Materials (2) Designated Outside Smoking Areas/times (3) Policy Violations with all residents that smoke. All smoke materials were	12/28/23

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reassessed at least monthly utilizing the Smoking Evaluation by a Licensed Nurse. The interdisciplinary team would review the care plans of smokers and update based on the Smoking Evaluation.

1. Resident #101 was admitted to the facility on 6/28/23 with diagnoses that included Hemiplegia (one sided weakness), Seizure disorder and Diabetes Mellitus II.

A review of the care plan dated 10/26/23 revealed that Resident #101 was an independent and safe smoker of cigarettes. The goal was for the Resident to continue to smoke safely in designated areas and would continue to use smoking materials safely through the next review. Interventions included staff assistance obtaining smoking materials from a secured storage area upon request, evaluate resident's continued ability to smoke safely on a consistent and regular basis, and for staff to observe for potential violations of the smoking policy. It further stated staff were to document and report observations to Administrator and/or Administrative staff and to provide education on safe smoking to the resident.

Resident #101's smoking evaluation dated 11/3/23 indicated the Resident was a safe smoker and may smoke in designated areas without supervision. A review of the Resident's smoking evaluations revealed they were performed monthly since admission to the facility in June 2023.

Resident #101 was observed walking alone out to the smoking area on 11/28/23 at 8:25 AM without stopping at the lock box area. He then removed

removed and secured per facility protocol.

On 12/18/23, Resident # 119 was educated regarding 1) Storage of Smoking Materials (2) Designated Outside Smoking Areas/times (3) Policy Violations with all residents that smoke. All smoke materials were removed and secured per facility protocol.

On 11/30/23, the Administrator initiated an audit of all residents who smoke for smoking paraphernalia. This audit is to identify any resident in possession of smoking material that was not stored per facility protocol. The Unit Managers will address all concerns identified during the audit to include removing smoke paraphernalia from resident care areas, storing smoke paraphernalia per facility protocol and education of the resident. The audit will be completed by 12/28/23.
On 11/30/23, the Administrator initiated an in-service with all residents who smoke regarding the smoke policy to include (1) Storage of Smoking Materials (2) Designated Outside Smoking Areas (3) Policy Violations. The in-service will be completed by 12/28/23.
On 11/30/23, the Staff Development Coordinator initiated an in-service for all facility staff regarding Monitoring Smoking Paraphernalia to include (1) Staff should ensure all smoke paraphernalia is returned immediately upon return to the facility (2) Staff should report to the assigned nurse, nurse supervisor, Director of Nursing, or Administrator immediately for any concerns related to

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F 689	Continued From page 17 smoking materials from his front shirt pocket and proceeded to light a cigarette. In an interview with Resident #101 on 11/28/23 at 8:30 AM he revealed he smoked several times a day. He further stated there were lock boxes for Residents to keep their smoking materials in, and each box had a key that was kept by the Resident it was assigned to. He was unaware if staff knew he kept his smoking materials on his person. An observation of the smoking area on 11/30/23 at 08:25 AM revealed metal shelving with lock boxes secured to the shelves. Each box was individually numbered. An interview with Nursing Assistant (NA) #1 on 11/30/23 at 9:30 AM stated she believed Residents were prohibited from keeping smoking materials on their person or in their rooms. She was unaware of where Resident #101 kept his smoking materials. An interview with Nurse #2 revealed Residents had a smoking evaluation done on admission and then monthly by Nursing to assess if the Resident could remain an independent smoker, or if they needed supervision for safety. She further stated she was unaware of where Resident #101 kept his smoking materials. In an interview with the Director of Nursing (DON) on 11/30/23 at 10:00 AM, she indicated that staff should notify her if a Resident had smoking materials on their person or had not utilized the lock box system. She stated she was unaware that Resident #101 kept smoking materials on his person instead of using the lock box. The DON indicated that staff had a duplicate key for each	F 689	smoke safety or any resident who has smoke paraphernalia that is not secured properly. This in-service will be completed by 12/28/23. After 12/28/23, any staff who has not worked or completed the in-service will complete prior to the next scheduled work shift. All newly hired staff will be in-service during orientation by the Staff Facilitator regarding Monitoring Smoking Paraphernalia. The Quality Assurance Nurse, Staff Development Coordinator, Unit Managers, Social Worker and Activities staff will complete observations of smoke sessions two times a week x 4 weeks then weekly x 1 month using the Smoke Paraphernalia Audit Tool. This audit is to ensure residents return smoke paraphernalia at the end of each smoke session and smoke paraphernalia is secured by staff per facility protocol. The Quality Assurance Nurse, Staff Development Coordinator, Unit Managers, Social Worker and Activities staff will address all concerns identified during the audit to include securing smoke paraphernalia per facility protocol, education of the resident and/or notification of the Director of Nursing (DON) or Administrator of all concerns. The Director of Nursing will review the Smoking Paraphernal Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the Smoking Paraphernalia Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will	

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F 689	Continued From page 18 box in case a key was lost. An interview with the Administrator on 11/30/23 at 1:00 PM indicated that staff smoked outside in the same area as the Residents. She further stated staff were able to supervise the smoking area from inside the building in case of emergency. She indicated there was no system in place to check if independent smokers were using the lock boxes and she was unaware of any Residents not using the lock boxes for smoking materials safe keeping. 2. Resident #107 was admitted to the facility on 8/30/23 with diagnoses that included Diabetes Mellitus II, Chronic Obstructive Pulmonary Disease and Heart Failure. A review of Resident #107's quarterly Minimum Data Set (MDS) dated 1/7/23 revealed the resident was cognitively intact with no behaviors. It also indicated the Resident was a tobacco user. A review of Resident #107's care plan dated 8/7/23 revealed the Resident was an independent and safe smoker of cigarettes. The goal was for the Resident to continue to smoke safely in designated areas and would continue to use smoking materials safely through the next review. Interventions included staff assistance obtaining smoking materials from a secured storage area upon request, evaluate resident's continued ability to smoke safely on a consistent and regular basis, and for staff to observe for potential violations of the smoking policy. It further stated staff were to document and report observations to Administrator and/or Administrative staff and to provide education on safe smoking to the	F 689	meet monthly for 2 months and review the Smoking Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 689	Continued From page 19	F 689		

resident.

Resident #107's smoking evaluation dated 11/1/23 indicated the Resident was a safe smoker and may smoke in designated areas without supervision. A review of the Residents smoking evaluations revealed they were performed monthly since admission to the facility in August 2023.

Resident #107 was observed wheeling himself out to the smoking area in his wheelchair on 11/28/23 at 8:45 AM. He then removed smoking materials from his front shirt pocket and proceeded to light a cigarette without first going to the lock box area.

An observation of the smoking area on 11/30/23 at 8:25 AM revealed metal shelving with lock boxes secured to the shelves. Each box was individually numbered.

In an interview with Resident #107 on 11/28/23 at 8:50 AM he revealed he smoked several times a day. He stated in the interview there were lock boxes for Residents to keep their smoking materials in, and each box had a key that was kept by the Resident it was assigned to. The Resident stated he did not use the lock box. He further stated staff knew he kept smoking materials on his person as he had refused to give them to staff or use the lock box.

In an interview with Nursing Assistant (NA) #1 on 11/30/23 at 9:37 AM, she stated she believed Residents were prohibited from keeping smoking materials on their person or in their rooms, and she believed Resident #107 kept his smoking materials at the Nurses station.

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An interview with Nurse #1 revealed Residents had a smoking evaluation done on admission and then monthly by Nursing to assess if the Resident could remain an independent smoker, or if they needed supervision for safety. She further stated Resident #107 kept his smoking materials on his person as he had refused to give them to Nursing in the past. Nurse #1 further revealed a large plastic toolbox that was kept at the Nurses station that had three packs of cigarettes inside that had no names on them. She further stated they used to use this toolbox to keep Resident smoking materials before they implemented the lock box system. Nurse #1 did not know to whom the cigarettes belonged. It was observed that the toolbox was not kept locked.

In an interview with the Director of Nursing (DON) on 11/30/23 at 10:00 AM, it was revealed that staff should have notified her if a Resident had smoking materials on their person or were not utilizing the lock box system. She was unaware there were cigarette packs in the toolbox at the nurse's station. She further stated she was unaware that Resident #107 kept smoking materials on his person instead of using the lock box. The DON indicated that staff had a duplicate key for each box in case a key was lost.

An interview with the Administrator on 11/30/23 at 1:00 PM indicated that staff smoked outside in the same area as the Residents. She further stated staff were able to supervise the smoking area from inside the building in case of emergency. She indicated there was no system in place to check if independent smokers were using the lock boxes and she was unaware of any Residents not using the lock boxes for smoking

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materials safe keeping.

3. Resident #119 was admitted to the facility on 2/14/2023 with diagnoses that included acquired absence of right leg below the knee, Congestive Heart Failure and Chronic Obstructive Pulmonary Disease.
A review of Resident #119's quarterly Minimum Data Set (MDS) dated 10/27/23 revealed the resident was cognitively intact with no behaviors. It also indicated the Resident was a tobacco user.

A review of the care plan dated 10/26/23 revealed that Resident #119 was an independent and safe smoker of cigarettes. The goal was for the Resident to continue to smoke safely in designated areas and would continue to use smoking materials safely through the next review. Interventions included staff assistance obtaining smoking materials from a secured storage area upon request, evaluate resident's continued ability to smoke safely on a consistent and regular basis, and for staff to observe for potential violations of the smoking policy. It further stated staff were to document and report observations to Administrator and/or Administrative staff and to provide education on safe smoking to the resident.

Resident #119's smoking evaluation dated 11/1/23 indicated the Resident was a safe smoker and may smoke in designated areas without supervision. A review of the Residents smoking evaluations revealed they were performed monthly since admission to the facility in February 2023.

In an interview with Resident #119 on 11/28/23 at 12:10 PM he revealed he smoked on days he did

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not have dialysis. He stated in the interview there were lock boxes for Residents to keep their smoking materials in, and each box had a key that was kept by the Resident it was assigned to. The Resident stated he does not use the lock box as he only smokes a few times a week. He was unaware if staff knew he kept his smoking materials on his person.
An observation of the Resident on 11/30/23 at 08:19 AM revealed Resident was outside in the designated smoking area when I arrived. He had not yet started to smoke. Resident #119 removed a pack of cigarettes from the back of his wheelchair.

An observation of the smoking area on 11/30/23 at 08:25 AM revealed metal shelving with lock boxes secured to the shelves. Each box is numbered.

An interview with Nursing Assistant (NA) #1 on 11/30/23 at 9:30 AM stated she believed Residents were prohibited from keeping smoking materials on their person or in their rooms. She was unaware of where Resident #119 kept his smoking materials.

An interview with Nurse #2 revealed Residents had a smoking evaluation done by Nursing before being allowed to smoke at the facility. This evaluation was to assess if the Resident can be an independent smoker, or if they need supervision for safety. The evaluation was completed monthly. She further stated she was unaware of where Resident #119 kept his smoking materials.

In an interview with the Director of Nursing (DON) on 11/30/23 at 10:00 AM, it was revealed that

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F 689	Continued From page 23 staff should have notified her if a Resident had smoking materials on their person or were not utilizing the lock box system. She further stated she was unaware that Resident #119 kept smoking materials on his person instead of using the lock box. The DON indicated that staff had a duplicate key for each box in case a key was lost. An interview with the Administrator on 11/30/23 at 1:00 PM indicated that staff smoked outside in the same area as the Residents. She further stated staff were able to supervise the smoking area from inside the building in case of emergency. She indicated there was no system in place to check if independent smokers were using the lock boxes and she was unaware of any Residents not using the lock boxes for smoking materials safe keeping.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		12/28/23

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F 812	Continued From page 24 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain clean dishes that were ready for use and failed to dry small rectangular bowls prior to stacking on the tray line ready for use during 1 of 2 kitchen observations. This practice had the potential to affect food served to all residents. Findings included: During a follow up observation tour of the kitchen on 11-29-23 at 11:42am with the Dietary Manager, the following concerns were observed. " There were 12 dinner plates on the tray line ready to be used for the lunch meal that contained yellow and/or black particles. " The lunch tray line had small rectangular bowls that were ready to be used for the lunch meal. The observation revealed 57 of the bowls were stacked wet and contained yellow/black particles. The Dietary Manager was interviewed on 11-29-23 at 12:10pm. The Dietary Manager confirmed the 12 dinner plates, and 57 small rectangular bowls were on the tray line ready to be used for the lunch meal. He explained the dishes went through a two-step check for cleanliness and dryness. The Dietary Manager stated the staff member who ran the dishwasher would be the first person to check all dishware for cleanliness and ensure the dishes were dry prior to placing them on the tray line. He said he was the second person to check the dishware to ensure the dishes were clean and dry once they	F 812	F 812 On 11/29/23, the dietary manager, under the supervision of the dietary consultant, removed the 12 dinner plates from the tray line containing yellow and/or black particles and removed the 57 small, rectangular bowls from the lunch tray line that were stacked wet and contained yellow/black particles. The 12 dinner plates and 57 small, rectangular bowls were re-cleaned and checked twice by the dietary manager and dietary consultant to ensure all were cleaned and dried appropriately prior to being placed in the line for use. On 11/30/23, the administrator conducted a thorough inspection of the kitchen to include observation of plates and small, rectangular bowls stored for the tray line. There were no issues identified during the inspection. On 11/29/23, an in-service was initiated by the dietary consultant and dietary manager for all dietary staff regarding the policy on Kitchen Cleaning Procedures to include ensuring that all dishware to include but not limited to plates and small rectangular bowls are completely cleaned and dried prior to storing. The in-service will be completed by 12/28/23. After 12/28/23, any dietary staff member that has not received the in-service will be	

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F 812	Continued From page 25 were on the tray line. The Dietary Manager explained he had been "too busy" to check the dishware today (11-29-23). He also explained the kitchen staff had been in-serviced in the past that dishware could not be stacked wet, and he did not know why staff would have stacked the small rectangular bowls wet on the tray line. The Dietary Manager stated he expected staff to ensure dishes were clean and dry prior to placing them on the tray line for use. During an interview with the Administrator on 11-29-23 at 2:37pm, the Administrator explained that the Dietary Manager was new and that the Corporate Dietary Consultant was training him. The Administrator stated she would expect dishes to be clean and dry prior to the dietary staff serving food.	F 812	educated prior to the next scheduled shift. All newly hired dietary staff members will be in-service on Kitchen Cleaning Procedures during orientation by the Staff Development Coordinator (SDC). The Director of Nursing and/or SDC will conduct kitchen rounds weekly x 4 weeks, then monthly x 1 month to ensure all dishware to include but not limited to dinner plates and small, rectangular bowls are cleaned and dried completely prior to being placed in the line for use. Any concerns identified during the audit will be immediately addressed by the administrator to include providing additional training as appropriate. The Administrator will review the Kitchen Audit tool weekly x 4 weeks, then monthly x 1 month to ensure completion. The administrator will present the findings of the Kitchen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The QAPI Committee will meet monthly for 2 months and review the Kitchen Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 867 SS=F	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	F 867		12/28/23

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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.

§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

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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 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

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F 867	Continued From page 28 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 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This was for one repeat deficiency in the area of Medicaid/Medicare Coverage Liability Notice (F582) originally cited on 7/29/21 during a recertification and complaint investigation survey and subsequently recited on 11/30/23 during the	F 867	F 867 QAPI/QAA Improvement Activities On 12/20/2023, the Clinical Consultant initiated an audit of all previous citations from 7/29/2021 to 11/27/2023 related to F 582 Medicaid/Medicare Coverage/Liability Notice to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA	

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F 867	Continued From page 29 recertification and complaint investigation survey. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. Findings included: This tag is cross referenced to: F582: Based on record review and staff interviews, the facility failed to provide a complete Skilled Nursing Facility Advanced Beneficiary Notice of non-coverage (SNF ABN) by omitting the estimated out of pocket cost for care for 3 of 3 residents reviewed for beneficiary notices (Residents #70, #134, #393). During the recertification and complaint investigation survey of 7/29/21, the facility failed to provide an acknowledged Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) and a Notice of Medicare Non-Coverage prior to discharge from Medicare Part A skilled services. During an interview on 11/30/23 at 12:14 PM, the Administrator revealed she was unaware of the need to complete the cost rate on the SNF ABN form.	F 867	Committee by the Director of Nursing (DON) for any concerns identified. The Clinical Consultant will address all concerns identified during the audit to include but not limited to the education of staff. This audit will be completed by 12/28/2023. On 12/8/2023, the Clinical Consultant conducted an in-service with the Administrator, Director of Nursing (DON), and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include pharmacy services and infection control. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. All newly hired administrators, DONs, and QA nurses will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns related to F 582 Medicaid/Medicare Coverage/Liability Notice will be taken to the Quality Assurance committee for review monthly x 3 months by the Director of Nursing (DON). The Quality Assurance committee will review the data and determine if the plans of correction are being followed, if changes in plans of action are required to improve outcomes, if further staff	

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F 867	Continued From page 30	F 867	education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse and/or the DON. The Clinical Consultant will ensure the facility is maintaining an effect QA program by reviewing the Quality Assurance and Performance Improvement (QAPI) quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions related to F 582 Medicaid/Medicare Coverage/Liability Notice and all current citations and QA plans are followed and maintained quarterly x2. The Clinical Consultant will immediately retrain the Administrator, DON, and QA nurse for any identified areas of concern. The results of the monthly Quality Assurance meeting minutes will be presented by the Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	