STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING ______ B. WING ______	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	**3322 VILLAGE ROAD ROCKY MOUNT, NC 27804**

(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 12/10/23 through 12/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3IUC11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/10/23 through 12/13/23. Event ID#3IUC11. The following intake was investigated NC00209744. 2 of the 2 complaint allegations did not result in deficiency.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		12/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/03/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 640	Continued From page 1 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to transmit the discharge Minimum Data Set (MDS) assessments for 11 of 13 residents reviewed for discharge. (Resident #77, Resident #38, Resident #11, Resident #52, Resident #55, Resident #33, Resident #34, Resident #73, Resident #26, Resident #22, Resident #4). The findings included:	F 640	640 Encoding/Transmitting Resident Assessments Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law.	

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F 640	Continued From page 2 a) Resident #77 was admitted to the facility on 6/7/23. On 12/13/23 Resident # 77's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 6/15/23 was observed in the electronic medical record as "completed" and not transmitted. b) Resident #38 was admitted to the facility on 6/26/23. On 12/13/23 Resident # 38's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/3/23 observed in the electronic medical record as "completed" and not transmitted. c) Resident #11 was admitted to the facility on 7/19/23. On 12/13/23 Resident # 11's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/3/23 observed in the electronic medical record as "completed" and not transmitted. d) Resident #52 was admitted to the facility on 7/4/23. On 12/13/23 Resident # 52's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 7/27/23 observed in the electronic medical record as "completed" and not transmitted. e) Resident #55 was admitted to the facility on 7/14/23. On 12/13/23 Resident # 55's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/4/23 observed in the electronic medical record as "completed" and not transmitted. f) Resident #33 was admitted to the facility on 7/26/23. On 12/13/23 Resident # 33's discharge assessment with an Assessment Reference Date	F 640	During Annual Survey conducted December 10th, 2023, through December 13th 2023 it was identified that the facility failed to transmit 11 of 13 residents reviewed for discharge assessments to CMS. On December 12th, 2023, all assessment were found to be completed and were subsequently transmitted. On December 12th, 2023, Director of Clinical Reimbursement Services completed an Audit of all due assessment for the past six months to ensure transmission. Any assessments in need of transmission were transmitted. On December 12th, 2023, both MDS Coordinators were educated by The Director of Clinical Reimbursement Services and the Administrator on the importance of timely transmission of assessments. The Director of Clinical Reimbursement Services, Administrator or designee will complete an audit of assessment transmissions on all due assessments for four weeks. Followed by an audit of five assessment transmissions for four weeks and then three assessment transmission for an additional four weeks. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance	

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F 640	Continued From page 3 (ARD, the last day of the 7-day lookback period) of 8/12/23 observed in the electronic medical record as "completed" and not transmitted. g) Resident #34 was admitted to the facility on 7/18/23. On 12/13/23 Resident # 34's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/5/23 observed in the electronic medical record as "completed" and not transmitted. h) Resident #73 was admitted to the facility on 8/2/23. On 12/13/23 Resident # 73's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/26/23 observed in the electronic medical record as "completed" and not transmitted. i) Resident #26 was admitted to the facility on 7/13/23. On 12/13/23 Resident # 34's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 7/21/23 observed in the electronic medical record as "completed" and not transmitted. j) Resident #22 was admitted to the facility on 7/25/23. On 12/13/23 Resident # 34's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/17/23 observed in the electronic medical record as "completed" and not transmitted. k) Resident #4 was admitted to the facility on 7/25/23. On 12/13/23 Resident # 34's discharge assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 8/8/23 observed in the electronic medical record as "completed" and not transmitted.	F 640	committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial compliance is December 13th, 2023.	

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F 640	Continued From page 4 An interview was conducted with MDS (Minimum Data Set) Nurse #1 on 12/13/23 at 11:00 AM, she stated the assessments were completed and signed on time but were not transmitted. The MDS Nurse revealed it was an error. In an interview with the Director of Nursing (DON) on 12/13/23 at 1:48 PM she revealed they now had two MDS Nurses and would do more tracking of resident's assessments. An interview was conducted with the Administrator on 12/13/23 at 2:01 PM. She stated that they would pull the weekly validation report and check that the MDS assessments were transmitted.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately complete the Minimum Data Set (MDS) for dialysis for 1 of 20 residents reviewed for MDS assessments. (Resident #61) Findings Included: Resident #61 was admitted to the facility on 10/31/23 with diagnosis that included end stage renal disease. Physician order dated 10/31/23 read dialysis days are Monday Wednesday, and Friday.	F 641	F641 Accuracy of Assessments Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. During Annual Survey conducted December 10th, 2023, through December 13th, 2023, it was identified that the facility failed to code dialysis on one resident # 61’s MDS assessment out of 20 residents	12/13/23

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F 641	Continued From page 5 Review of the admission Minimum Data Set (MDS) dated 11/7/23 indicated Resident #61 did not receive dialysis. An interview was conducted on 12/12/23 at 11:32 A.M. with the MDS nurse. The MDS nurse reviewed the admission MDS and confirmed it was inaccurate. The MDS nurse stated when she completed Resident #61 admission MDS, she overlooked Resident #61 received dialysis and she stated Resident #61's admission MDS should have been marked to show Resident #61 received dialysis treatment. An interview was conducted on 12/13/23 at 10:11 A.M. with the Director of Nursing (DON). During the interview, the DON confirmed Resident #61 had a physician order dated 10/31/23 that showed Resident #61 received dialysis treatment three times a week since her admission. The DON further stated Resident #61's MDS should reflect Resident #61 received dialysis treatments and she felt it was an oversite on the part of the MDS nurse when she completed Resident #61's admission MDS. An interview was conducted on 12/13/23 at 1:42 P.M. with the Administrator. During the interview, the Administrator stated Resident #61's MDS should be documented to show Resident #61 received dialysis treatment. The Administrator further stated she felt the MDS nurse made a mistake when she completed Resident #61's admission MDS.	F 641	reviewed. Resident was reviewed to have dialysis order since admission. On December 12th, 2023, Resident #61's assessment was modified to include dialysis. On December 12th, 2023, all current residents with dialysis orders were reviewed to ensure the accuracy of their assessments to include dialysis. On December 12th, 2023, both MDS Coordinators were educated by Director of Clinical Reimbursement Services the Administrator on the importance of accuracy in the MDS assessment. The MDS Coordinator will complete five full MDS assessment audits weekly for four weeks; then three full MDS assessment weekly for four weeks the one MDS assessment weekly for four weeks. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial compliance is December 13th, 2023	
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		12/15/23

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F 655	Continued From page 6	F 655		

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.

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F 655	Continued From page 7 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours after admission for 2 of 20 residents (Resident #7 and Resident #78) for care planning. The findings included: 1. Resident #7 was admitted to the facility on 2/3/23 with diagnoses that included acute respiratory disease, dysphagia (difficulty swallowing foods or liquids), and acute kidney failure. Resident #7's electronic medical record revealed a baseline care plan was developed on 2/6/23 and showed completed on 2/7/23. An interview was conducted on 12/12/23 at 11:23 A.M. with the MDS nurse. During the interview, the MDS nurse stated the baseline care plan was completed by the nursing staff within 48 hours from the time a resident was admitted into the facility. The MDS nurse was unable to provide a reason why Resident #7's baseline care plan was not developed within 48 hours of admission. An interview was conducted on 12/13/23 at 11:03 A.M. with Nurse #1 who admitted Resident #7. During the interviews, Nurse #1 stated she had never initiated a baseline care plan for a newly admitted resident, and she believed the unit	F 655	F655 Baseline Care Plan Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. During Annual Survey conducted December 10th, 2023, through December 13th, 2023, it was identified that the facility failed to initiate a baseline care plan within forty-eight hours on two residents out of twenty that were reviewed. Resident #7 and resident #78 both had baseline care plans that were initiated on day three after their admission. On December 15th, 2023, MDS completed a review of Resident #7 and resident #78 comprehensive care plans to ensure accuracy. Both care plans were accurate, and no issues were identified. On December 14th, 2023, MDS Coordinator completed a retrospective review of all new admissions in the last thirty days to ensure completion of baseline care plans and/or comprehension care plans if appropriate. Any resident without initial care plan or comprehensive care plan will have care plan competed on December 15th 2023.	

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F 655 Continued From page 8

manager was responsible for initiating the baseline care plan. Nuse #1 stated she did not complete an initial care plan for Resident #7.

An interview was conducted on 12/12/13 at 9:32 A.M. with the Unit Manager. The Unit Manager stated when a resident was admitted to the facility, most of the time the nurses on the floor would develop the baseline care plan. If there were a lot of admissions, then the Unit Manager would develop the baseline care plan the following day. The Unit Manager was unable to provide a reason why Resident #7's care plan was not developed within 48 hours from admission.

An interview was conducted on 12/13/23 at 11:11 A.M. with the Director of Nursing (DON). The DON stated the admitting nurse was responsible to start the baseline care plan when a resident was admitted to the facility and if the admitting nurse had not started the baseline care plan, then the next nurse who took over the resident's care would complete the task. The DON explained the baseline care plan should be initiated and completed within 48 hours of admission into the facility. During the interview, the DON stated Resident #7's care plan was overlooked and was initiated when staff identified the care plan had not been started.

2. Resident #78 was admitted to the facility on 7/17/23 with diagnoses that included cancer, type two diabetes mellitus, atrial fibrillation, and dementia.

Resident #78's electronic medical record

F 655

On December 15th, 2023, the Regional Clinical Manager educated both MDS Coordinators; Dietary Manager; Administrative Nursing Staff; and Administrator on baseline care plans and the importance of ensuring baseline care plans are initiated within 48-hours of admission.
Director of Nursing or designee will audit all new admissions for initiation of baseline care plan within forty-eight hours for four weeks. Then Director of Nursing will audit five new admissions a week for four weeks for base line care plans. Followed by an audit of three new admissions weekly for four weeks for baseline care plans.
Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance.

The correction date for substantial compliance is December 15, 2023.

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F 655	Continued From page 9 revealed a baseline care plan was developed on 7/20/23 and showed completed on 7/21/23. An interview was conducted on 12/12/23 at 11:23 A.M. with the MDS nurse. During the interview, the MDS nurse stated the baseline care plan was completed by the nursing staff within 48 hours from the time a resident was admitted into the facility. The MDS nurse was unable to provide a reason why Resident #78's initial care plan was not developed within 48 hours of admission. An interview was conducted on 12/13/23 at 11:07 A.M. with Nurse #2 who admitted Resident #78. During the interviews, Nurse #2 stated when Resident #78 was admitted she completed the required head to toe assessments, but she did not begin the baseline care plan. Nurse #2 stated she believed the Unit Manager was responsible for developing the baseline care plan for residents. An interview was conducted on 12/12/13 at 9:32 A.M. with the Unit Manager. The Unit Manager stated when a resident was admitted to the facility, most of the time the nurses on the floor would initiate the baseline care plan. If there were a lot of admissions, then the Unit Manager would initiate the baseline care plan the following day. The Unit Manager was unable to provide a reason why Resident #78's care plan was not initiated within 48 hours from admission. An interview was conducted on 12/13/23 at 11:11 A.M. with the Director of Nursing (DON). The DON stated the admitting nurse was responsible to start the baseline care plan when a resident was admitted to the facility and if the admitting nurse had not started the baseline care plan, then	F 655		

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F 655	Continued From page 10 the next nurse who took over the resident's care would complete the task. The DON explained the baseline care plan should be initiated and completed within 48 hours of admission into the facility. During the interview, the DON stated Resident #78's care plan was overlooked and was developed when staff identified the care plan had not been started.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		12/13/23

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THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	**3322 VILLAGE ROAD ROCKY MOUNT, NC 27804**

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F 657 Continued From page 11

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to update a resident's care plan for a resident with impaired swallowing for 1 of 20 residents whose care plans were reviewed (Resident #7).

The findings included:

Resident #7 was admitted to the facility on 2/3/23 with diagnosis that included acute respiratory disease and dysphagia (difficulty swallowing foods or liquids).

Resident #7's physician order dated 8/11/23 read NPO (nothing by mouth).

Review of the quarterly Minimum Data Set (MDS) dated 10/25/23 showed Resident #7 was severely cognitively impaired, he had a swallowing disorder of loss of liquids/solids when eating, coughing/choking when eating, and received 51% or more through a feeding tube.

Review of Resident #7's care plan last updated 11/16/23 showed a focus area Resident #7 had impaired swallowing related to dysphagia with potential for aspiration. Interventions included to encourage resident to eat/drink slowly, encourage resident to eat meals out of his room, monitor and report difficulties swallowing, use aspiration precautions, and refer to speech therapy as indicated.

An interview was conducted on 12/12/23 at 11:32 A.M. with the MDS nurse. The MDS nurse stated Resident #7 was eating pleasure food by mouth before a feeding tube was placed. The MDS

F 657

F657 Care Plan Timing and Revision
Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law.
During Annual Survey conducted December 10th, 2023, through December 13th 2023 it was identified that the facility failed to update a care plan for one resident out of twenty residents that were reviewed. Resident #7 was care planned to eat/drink slowly, and encourage resident to eat meals out of his room. Resident #7 diet was updated to be NPO on August 11th, 2023, and care plan was not updated to reflect this.
On December 12th, 2023, care plan for resident #7 was updated to remove dining room options for meals and to encourage resident to eat/drink slowly.
On December 12th, 2023, all current residents with NPO diets were audited to ensure they were not care planned as NPO.
On December 12th, 2023, both MDS Coordinators were educated by The Director of Clinical Reimbursement Services and the Administrator on the importance of Care Plan Accuracy.
The MDS coordinators will complete five full care plan audits weekly for four weeks; then three full care plan audits weekly for four weeks; then one care plan

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F 657	Continued From page 12 nurse indicated when the physician ordered Resident #7 to be nothing by mouth, his care plan should have been updated at that time to reflect the change. When the MDS nurse reviewed Resident #7's care plan she stated it appeared Resident #7's care plan was not updated. The MDS nurse stated the dietary manager was response for updating Resident #7's care plan. An interview was conducted on 12/13/23 at 12:50 P.M. with the Dietary Manager. During the interview, the Dietary Manager stated he updates resident care plans when he completed MDS assessments or when something was brought to his attention that needed correcting. The Dietary Manager stated Resident #7's interventions about eating should have been removed from his plan of care when the physician created an order Resident #7 was not to eat anything by mouth or when the MDS quarterly assessment review was completed. The Dietary Manager stated he was unsure why Resident #7's care plan was not updated. An interview was conducted on 12/13/23 at 11:11 A.M. with the Director of Nursing (DON). The DON stated when the physician wrote an order Resident #7 was to receive nothing by mouth was reviewed during a morning meeting, that included the MDS nurse and the Dietary Manager, Resident #7's care plan should have been updated to show the change in his eating ability and the interventions about eating deleted from his plan of care. The DON stated Resident #7's care plan not being updated was an oversite.	F 657	audit for four weeks. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial compliance is December 13th, 2023.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		12/15/23

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F 812	Continued From page 13 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews the facility failed to maintain kitchen equipment clean by failing to clean 1 of 1 plate warmer and 1 of 1 knife holder observed. This practice has the potential for cross contamination of food served to residents. The findings included: a. Observations of the kitchen were conducted on 12/1023 at 10:05 AM, and 12/12/23 at 12:18 PM the three cylinder well plate warmer was observed with dark black dried food particles inside each well. b. Observations of the kitchen conducted on 12/12/23 at 12:18 PM and 12/13/23 at 9:07AM revealed a buildup of dried food particles on top of the wall mounted magnetic knife holder.	F 812	F 812 Food Procurement, Store/Prepare/serve Sanitary Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On December 13th, 2023, an observation of the dietary kitchen revealed the facility failed to maintain clean kitchen equipment on one plate warmer and one knife holder. Once identified the plates; plate warmer; knives and knife holder were immediately cleaned.	

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F 812	Continued From page 14 During an interview with the Dietary Manager on 12/13/23 at 9:08 AM he stated he would add the plate warmer to the cleaning schedule and start daily cleaning audits. In an interview on 12/13/23 at 9:15 AM the Administrator stated she would have the kitchen do daily audits and keep the plate warmer clean.	F 812	On December 13th, 2023, a full kitchen sweep was completed by Dietary Manager, Regional Clinical Manager and Administrator to ensure there were no more crumbs located anywhere else. No issues were identified. On December 13th, 2023, education was started on how to properly clean the plate warmer and the importance of ensuring no food particles are left. Dietary Manger was educated by Administrator on the importance of cleaning schedules to include all equipment. All dietary staff will be educated by December 15th 2023, on the importance of cleaning the plate warmer and also the equipment cleaning schedules. Any dietary staff not educated by December 15th, 2023 will not be able to work until they are educated. The Lodge at Rocky Mount Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrected by utilizing a Quality Improvement (QI) Audit Tool, to review all weekly and monthly cleaning schedules. The monitoring will occur at least five time a week for four weeks, then three times a week for four weeks, and then one time a week for four weeks to monitor for trends or concerns by the Dietary Manager. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the	

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F 812	Continued From page 15	F 812	need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial compliance is December 15th 2023.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators,	F 867		12/15/23

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F 867	Continued From page 16 including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §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;	F 867		

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F 867	Continued From page 17 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;	F 867		

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Continued From page 18

(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, observations, 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 in place following the recertification and complaint investigations on 4/15/21 and 11/10/22. The deficiencies included: Care Plan Timing and Revision (F657) and Food Procurement/Store/Prepare/Serve Sanitary (F812). The continued failure during two or more federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.

Findings included:

This tag is cross-referenced to:

F657: Based on record review and staff interviews, the facility failed to update a resident's care plan for a resident with impaired swallowing for 1 of 20 residents whose care plans were reviewed (Resident #7).

During the recertification and complaint survey of 4/15/21, the facility was cited for failure to update a resident's Care Plan to include transfers with a mechanical lift.

An interview was conducted on 12/13/23 at 1:41 P.M. with the Administrator. The Administrator

F 867

F867 QAPI/QAA Improvement Activities

The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put in place following the annual recertification survey conducted on November 10th, 2023 on two incidents. During the annual recertification survey conducted on December 10, 2023, the survey team identified one inaccuracy on care plan for resident #7. In addition, on December 13th, 2023, facility failed to maintain a clean kitchen by the identification of "crumbs" in two separate locations.

Corrective Action:
A plan of correction was put into place, for each deficiency, at the time the deficiencies were cited. The plans of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined period of time. Monitoring of the plans of correction were presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued.

On December 15th, 2023, The Administrator initiated an in-service to all

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F 867	Continued From page 19 stated an additional Minimum Data Set (MDS) nurse was recently hired and in training. The newly hired MDS nurse was responsible for assisting with MDS assessments and care plans. She explained resident care plans were extensive and things get missed. During the interview, the Administrator further explained the facility should increase auditing to ensure the resident care plans are double checked for accuracy. F812: Based on observations, and staff interviews the facility failed to keep kitchen equipment clean by failing to clean 1 of 1 plate warmer and 1 of 1 knife holder observed. This practice has the potential for cross contamination of food served to residents. During the recertification and complaint survey of 11/10/22, the facility was cited for failure to maintain 2-chef salads with egg, at 41 degrees Fahrenheit (F) or below on the lunch meal tray line.	F 867	administrative staff regarding Quality Assurance Performance Improvement (QAPI) process including identifying and prioritizing quality deficiencies, systemically analyzing causes of quality deficiencies, developing, and implementing corrective action or performance improvement activities. This in-service included accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff worked until they received appropriate education. The QAPI committee will review the compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: December 15th, 2023	