STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 12/15/2023

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LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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E 000	Initial Comments An unannounced recertification and complain investigation survey were conducted 12/11/2023 to 12/15/2023. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID#7B2K11.	E 000		
F 000	INITIAL COMMENTS A complaint investigation and recertification survey were conducted 12/11/2023 to 12/14/2023. Aditional information was obtained on 12/15/2023. Therefore, the exit date was changed to 12/15/2023. Event ID # 7B2K11. The following intakes were investigated: NC00199267, NC00197768, NC00202138, NC00209764, NC00199928, NC00206507, and NC00194181. 3 of 18 complaint allegations resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.	F 565		1/5/24

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

Electronically Signed | 01/05/2024

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F 565	Continued From page 1 (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to resolve repeat grievances related to dietary issues that were reported during the Resident Council meetings for 8 of 11 months reviewed (January 2023, February 2023, March 2023, April 2023, May 2023, September 2023, October 2023, and November 2023). The findings included: Resident Council meeting minutes for 2023 were reviewed and revealed issues the Resident Council had identified: a. The Resident Council meeting minutes dated 1/12/2023 indicated that the food served for meals was cold, and no spoons were available.	F 565	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F565 The facility failed to resolve repeated grievances that were reported to the resident council meetings related to dietary issues for 8 of 11 months that resident council meetings were held	

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F 565	Continued From page 2 The Dietary Manager's written response to the resident council dated 1/13/2023 read: "We temp [check the temperature] of all food before it leaves dietary [department for meal delivery]. We have spoons." b. The Resident Council meeting minutes dated 2/9/2023 indicated that the facility was always out of jelly, the eggs and grits were cold, and the menus were repeated without variety. The Dietary Manager's written response to the resident council dated 2/9/2023 read: "We do have jelly; it's ordered once a month. I notified nursing about getting the food out faster, and sorry we go by a set menu." c. The Resident Council meeting minutes dated 3/9/2023 indicated that the food was always cold by the time the residents received their trays and the beverages were always hot (no ice). There was no response to the complaints. d. The Resident Council meeting minutes dated 4/25/2023 indicated that residents were receiving iced tea without ice in the drinks, the coffee was cold when delivered to the residents, the grits were lumpy, and one resident received out of date milk. The interventions dated 4/26/2023 read: "Activity Director will talk with dietary manager to resolve these issues;" and on 4/27/2023 the Dietary Manager's written response, "All issues [were] resolved. I talked to my [kitchen] employees to make sure we were all on the same page." e. The Resident Council meeting minutes dated 5/11/2023 indicated that the residents did not want Mexican food and were requesting more potatoes and onions. The minutes documented	F 565	(January 2023- November 2023). 1. Corrective action for resident(s) affected by the alleged deficient practice: An additional Resident Council meeting was held on 1/3/2024. Minutes were taken by the Activities Director. On 1/3/2024, grievances/concerns were addressed with the Administrator and the appropriate department managers following the facility's grievance process for resolution. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. Beginning with the 1/3/2024 resident council meeting, grievances/concerns, as well as any ongoing grievances/concerns were reviewed by the administrator with resident council members for timely resolution following the facility grievance process. No new grievances or concerns voiced during meeting. The Administrator to attend monthly resident council meeting at the request of resident council members to address any outstanding grievances or concerns and ensure facility following policy related to grievance process for resolution. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/3/2024, the Administrator educated the facility department heads on the following: Grievance Process The Administrator educated department heads on the grievance process and at the daily standup meeting on 1/3/2024	

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F 565	Continued From page 3 the resident council wanted more "Southern food", as well as steak, and fish. The Dietary Manager's written response to the resident council dated 5/12/2023 read: "Sorry, the food comes off a menu that's already put together and sent to me." f. The Resident Council meeting minutes dated 9/12/2023 indicated the food was delivered cold to the residents, and they were not receiving flatware or condiments. There was no response to the complaints. g. The Resident Council meeting minutes dated 10/10/2023 indicated the residents wanted a more versatile variety of menu items for breakfast and dinner. There was no response to the complaints from the dietary department. h. The Resident Council meeting minutes dated 11/20/2023 indicated the residents were requesting more snacks, and the food was not hot. The Dietary Manager's response to the resident council dated 11/20/2023 documented a response: "Residents discussed concerns with the kitchen manager during today's resident council meeting." The Resident Council meeting was observed on 12/12/2023 at 2:30 pm and 14 residents were in attendance. During resident interviews, Resident #47 indicated the food was cold when delivered to her room, and Resident #19, Resident #4, and Resident #58 agreed. The Resident Council President, Resident #58, reported the Resident Council brought up the same dietary department issues every month, but the facility did not resolve the issues.	F 565	and assigned responsibility for timely resolution of grievances. Going forward, Administrator or Director of Nurses (in his absence) will continue to assign responsibility for resolving grievances the morning after the Resident Council meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 1/4/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor compliance utilizing the F565 Quality Assurance Tool weekly for 4 weeks then monthly x 2 months or until resolved. The tool will monitor to ensure that grievances from resident council meetings are addressed following the grievance process and are in compliance. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS	

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F 565	Continued From page 4 An in-person interview was conducted with the former Administrator on 12/13/2023 at 3:21 PM. The former Administrator reported he left the facility for a sister facility in June 2023, and he did not recall the any grievances from the Resident Council. The former Administrator reported he did not recall hearing that the food was cold when it was delivered to the residents. The Dietary Manager (DM) was interviewed on 12/14/2023 at 8:47 AM. The DM reported she had been in her position for 1 year and she was aware of the Resident Council issues with the food temperature, and she had been checking the dish warmer to make certain it was heating the plates. The DM explained she was not aware she could make changes to the menu until recently, and the Registered Dietician made a list of substitutions. The DM reported test trays were tested by the Corporate Dietary Manager. The DM reported she wanted the residents to have a good variety of food that was served at the right temperature and tasted good. The Activity Director was interviewed on 12/14/2023 at 9:38 AM. The Activity Director reported she had been in her position for 3 months and when a resident expressed a concern or complaint during the Resident Council meetings, she went to the department head to discuss the issue. The Activities Director reported she had invited department heads to attend the resident council meetings to address any questions or concerns. During an interview with the current Administrator on 12/14/2023 at 3:06 PM, he reported he had been in the position since mid-September 2023, and he was not aware of the multiple issues the	F 565	Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/5/2024	

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F 565	Continued From page 5 Resident Council had with the food and dietary department. The Administrator reported the Resident Council provided the residents an opportunity to express concerns and have those concerns addressed. The Administrator explained that the facility should provide actions to resolve issues and if the response by the individual departments required revision, he should direct the revision and response.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		1/5/24

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F 580	Continued From page 6 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to notify the resident's responsible party (RP) of a change in roommate for 1 of 3 residents reviewed for notification of change (Resident #13). Findings included: Resident #13 was admitted to the facility on 2/10/2022 with diagnoses of dementia and kidney disease. An annual Minimum Data Set assessment dated 7/11/2023 indicated Resident #13 was severely cognitively impaired.	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F580 The facility failed to notify the residents responsible party of a change in roommate for 1 of 3 residents reviewed	

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F 580	Continued From page 7 On 12/11/2023 at 3:55 pm the RP was interviewed by phone and stated he was not notified Resident #13 would be getting a new roommate on 9/4/2023. He stated when he visited after 9/4/2023 the roommate was cussing, and he was concerned the cussing would upset Resident #13. During an interview with Nurse #1 by phone on 12/14/2023 at 10:53 am she stated she remembered Resident #13 having a change of roommate when she resided on the 100-hall, and the RP was upset because the roommate would cuss. Nurse #1 stated the roommate had not cussed at Resident #13, but she would talk to herself and say cuss words. Nurse #1 stated she thought the Social Worker notified the Responsible Parties of the resident when they are moved to a different room, but she was not sure if they notified the Responsible Parties of the resident that received a new roommate. The Social Worker was interviewed on 12/14/2023 at 3:12 pm and she stated she was on vacation when Resident #13 received the new roommate and she did not know who called the RP but Administrator #2, who was the interim administrator at that time, was responsible for managing the room changes while she was on vacation. On 12/14/2023 at 3:47 pm Administrator #1, the current administrator was interviewed, and he stated he was not the administrator in the building on 9/4/2023 when Resident #13 received a new roommate. Administrator #2, the previous administrator, was interviewed on 12/15/2023 at 12:24 pm and	F 580	for notification of change. 1.Corrective action for resident(s)affected by the alleged deficient practice: Resident #13 RP was made aware of resident #50 room change while in facility after room change occurred. Resident transferred to room 203 on 9/25/2023 at request of RP. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 1/4/2024, the Social Worker audited all residents with room change for the past thirty days to ensure resident or resident RP was notified of room change. The results of the audited revealed no other residents affected by alleged deficient practice. This audit was completed on 1/4/2024. On 1/4/2024, the administrator reeducated Social Worker related to Transfer of Resident Within the Facility Policy. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 1/3/2024 the Director of Nursing began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), and medication aides (full time, part time, and as needed, including agency) on Transfer of Resident Within the Facility Policy The Director of Nurses will ensure that all licensed nurses, RNs, LPNs, and Med Aides (full time, part-time, and as needed including agency) who do not complete the in-service training by 1/4/2024 will not	

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F 580	Continued From page 8 stated she did not remember Resident #13 and did not remember notifying the RP Resident #13 would be getting a new roommate. She also stated she would have asked the Nurse who had Resident #13 to call the RP if the Social Worker was not available. The Director of Nursing stated on 12/14/2023 at 12:35 pm that Nurse #2 worked on 9/2/2023 on the day shift and she asked her if she remembered Resident #13 receiving a new room ate that day. The Director of Nursing stated Nurse #2 said she did not remember if she called the RP to notify them Resident #13 received a new roommate.	F 580	be allowed to work until the training is completed. This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and as needed including agency.) and will be reviewed by the Quality Assurance process to verify that the change has been sustained 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will audit this process using the Quality Assurance Tool for Monitoring Compliance with the notification process for Transfers within the Facility. This audit will be completed Monday through Friday x 2 weeks and then weekly x 2 weeks, then monthly x 2 months or until resolved. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager and Dietary Manager. Date of Compliance: 1/5/2024	
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		

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§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication

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with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to complete 1 of 4 admission comprehensive Minimum Data Set (MDS) assessments within 14 days of an admission (Resident #233) and failed to complete comprehensive MDS assessments within 14 days of the Assessment Reference Date (ARD) [the last day of the assessment period] for 5 of 26 sampled residents (Resident #7, Resident #19, Resident #30, Resident #239, Resident #27).

The findings included:

1. a. Resident #233 was admitted to the facility on 7/28/2023.
A review of Resident #233's admission MDS assessment with an ARD of 8/4/2023 was signed

Past noncompliance: no plan of correction required.

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as completed on 8/16/2023.

2. a. Resident #7 was readmitted to the facility 7/30/2023.

A review of Resident #7's annual MDS with an ARD of 5/11/2023 was signed as completed on 5/28/2023.

b. Resident #7 was admitted to the facility 10/22/2019.

A review of the annual MDS with an ARD of 4/18/2023 was signed as completed on 5/8/2023.

c. Resident #30 was admitted to the facility 3/8/2019.

A review of the annual MDS with an ARD of 5/2/2023 was signed as completed on 5/18/2023.

d. Resident #239 was admitted to the facility on 6/19/2023.

A Significant Change Assessment with an assessment reference date (ARD) of 10/10/2023 was completed on 10/26/2023.

e. Resident #27 was admitted to the facility on 7/28/2023.

A review of Resident #27's Admission Minimum Data Set (MDS) assessment had an assessment reference date (ARD) scheduled for 8/4/2023. The MDS assessment was signed and completed on 8/16/2023.

The facility MDS nurse was not available for

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interview during the survey.

An interview was conducted with the Clinical Reimbursement Consultant on 12/14/2023 at 2:09 PM. The Clinical Reimbursement Consultant revealed she became aware of the late admission and comprehensive MDS assessments after running a report in 9/14/2023 and a Performance Improvement Plan (PIP) was developed at that time. The Clinical Reimbursement Consultant explained the MDS nurse was unable to meet the expectations of the PIP and the PIP was modified on 11/30/2023, to include hiring additional MDS nurses to assist with completing the admission and the comprehensive MDS assessments in a timely manner.

The Regional Nurse Consultant was interviewed on 12/14/2023 at 2:54 pm and she reported the facility had received the report from the Clinical Reimbursement Consultant in September 2023 and the facility developed a PIP and the goals were not being met by the MDS nurse, so they modified the plan on 11/30/2023. The Regional Nurse Consultant explained the facility had hired additional MDS nurses to help with the completion of MDS assessments.

During an interview with the Administrator on 12/14/2023 at 3:06 PM, he reported he started his position on 9/14/2023 and received the late MDS report from the Clinical Reimbursement Consultant. The Administrator explained the facility had an ad hoc Quality Improvement Meeting and developed a PIP, but upon review on 11/30/2023, discovered that the goals were not being met, and the Quality Improvement team developed another PIP.

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Nurse #4 was interviewed on 12/14/2023 at 3:41 PM. Nurse #4 reported she was newly hired to assist with the completion of MDS assessments for the facility and she had received education regarding the timeliness of MDS completion for admission and comprehensive assessments.

The facility plan of correction was reviewed and it read:

On 11/29/2023 the facility identified past due admission and comprehensive MDS assessments were not being completed and submitted. The Clinical Reimbursement Consultant identified residents who were impacted by the late completion of the admission or comprehensive MDS assessments and discovered 46 late assessments during an audit of the past 60 days for all current and discharged residents. Education was provided by the Administrator to the MDS nurses on MDS completion on 12/1/2023. The Administrator or designated manager will monitor MDS assessments weekly for 4 weeks and monthly for 2 months using the Quality Assurance tools to ensure assessments were completed timely. The reports will be presented to the weekly Quality Assurance meeting by the Administrator or the Director of Nursing. Compliance will be monitored, and an ongoing auditing program will be reviewed at the weekly Quality Assurance meeting. The date of compliance was 12/2/2023.

The plan of correction was validated by review of the education provided, review of the audits completed by the facility, and interview with the newly hired MDS nurse regarding education received and monitoring in place. Admission and

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F 636	Continued From page 14 comprehensive MDS completed after 12/2/2023 were were reviewed and no issues were identified. The facility date of compliance of 12/2/2023 was validated.	F 636		
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) [the last day of the assessment period] for 6 of 21 sampled residents (Resident #30, Resident #6, Resident #7, Resident #19, Resident # 236, and Resident #50). The findings included: A. Resident #30 was admitted to the facility on 3/8/2019. A review of Resident #30's quarterly MDS assessment with an ARD of 8/1/2023 was signed as complete on 8/17/2023. B. Resident #6 was admitted to the facility on 2/7/2022. A review of Resident #6's quarterly MDS assessment with an ARD of 11/10/2022 was signed as completed on 12/1/2022.	F 638	Past noncompliance: no plan of correction required.	

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C. Resident #7 was readmitted to the facility on 7/30/2023.

A review of Resident #7's quarterly MDS assessment with an ARD of 11/2/2023 was signed as completed on 11/28/2023.

D. Resident #19 was admitted to the facility on 10/22/2019.

A review of Resident #19's quarterly MDS assessment with an ARD of 1/19/2023 was signed as completed on 2/14/2023.

E. Resident #236 was admitted to the facility on 2/17/2023.

A quarterly Minimum Data Set (MDS) assessment for Resident #236 with an assessment reference date (ADR) of 5/17/2023 was signed as completed on 6/7/2023.

F. Resident #50 was admitted to the facility on 9/5/2023.

A quarterly MDS assessment with an assessment reference date (ADR) of 11/3/2023 was signed as completed on 11/29/2023.

The facility MDS nurse was not available for interview during the survey.

An interview was conducted with the Clinical Reimbursement Consultant on 12/14/2023 at 2:09 PM. The Clinical Reimbursement Consultant revealed she became aware of the late quarterly MDS assessments after running a report in 9/14/2023 and a Performance

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Improvement Plan (PIP) was developed at that time. The Clinical Reimbursement Consultant explained the MDS nurse was unable to meet the expectations of the PIP and the PIP was modified on 11/30/2023, to include hiring additional MDS nurses to assist with completing the quarterly MDS assessments in a timely manner.

The Regional Nurse Consultant was interviewed on 12/14/2023 at 2:54 pm and she reported the facility had received the report from the Clinical Reimbursement Consultant in September 2023 and the facility developed a PIP and the goals were not being met by the MDS nurse, so they modified the plan on 11/30/2023. The Regional Nurse Consultant explained the facility had hired additional MDS nurses to help with the completion of MDS assessments.

The Administrator was interviewed on 12/14/2023 at 3:06 PM, he reported he started his position on 9/14/2023 and received the late MDS report from the Clinical Reimbursement Consultant. The Administrator explained the facility had an ad hoc Quality Improvement Meeting and developed a PIP, but upon review on 11/30/2023, discovered that the goals were not being met, and the Quality Improvement team developed another PIP.

Nurse #4 was interviewed on 12/14/2023 at 3:41 PM. Nurse #4 reported she was newly hired to assist with the completion of MDS assessments for the facility and she had received education regarding the timeliness of MDS completion for quarterly assessments.

The facility plan of correction was reviewed and it read:

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F 638	Continued From page 17 On 11/29/2023 the facility identified past due quarterly MDS assessments were not being completed and submitted. The Clinical Reimbursement Consultant identified residents who were impacted by the late completion of the quarterly MDS assessments and discovered 46 late assessments during an audit of the past 60 days for all current and discharged residents. Education was provided by the Administrator to the MDS nurses on MDS completion on 12/1/2023. The Administrator or designated manager will monitor MDS assessments weekly for 4 weeks and monthly for 2 months using the Quality Assurance tools to ensure assessments were completed timely. The reports will be presented to the weekly Quality Assurance meeting by the Administrator or the Director of Nursing. Compliance will be monitored, and an ongoing auditing program will be reviewed at the weekly Quality Assurance meeting. The date of compliance was 12/2/2023. The plan of correction was validated by review of the education provided, review of the audits completed by the facility, and interview with the newly hired MDS nurse regarding education received and monitoring in place. Quarterly MDS assessments completed after 12/2/2023 were reviewed and no issues were noted with late assessments. The facility date of compliance of 12/2/2023 was validated.	F 638		
F 641 SS=B	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	F 641		

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F 641	Continued From page 18 by: Based on record reviews and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments for 3 of 26 sampled residents (Resident #30, Resident #6, and Resident #19). The findings included: A. Resident #30 was admitted to the facility on 3/8/2019. A review of medication orders for Resident #30 revealed he was not prescribed antipsychotic medications. A review of the Quarterly MDS dated 11/1/2023 documented "yes" that Resident #30 was taking antipsychotic medications. B. Resident #6 was admitted to the facility on 2/7/2022. A review of physician orders for Resident #6 revealed no orders for enteral feedings. A review of the quarterly MDS dated 10/10/2023 documented "no" Resident #6 had not received enteral feedings. The MDS assessment documented Resident #6 received 500 milliliters or less and 25% of calories or less from enteral feedings. C. Resident #19 was admitted to the facility on 10/22/2019. A review of physician orders for Resident #19 revealed no orders for enteral feedings.	F 641	Past noncompliance: no plan of correction required.	

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A review of the quarterly MDS dated 9/27/2023 revealed documentation that Resident #19 received parenteral feeding and enteral feeding, and she received 500 or more milliliters and 51% of her calories via enteral feeding.

The facility MDS nurse was not available for interview during the survey.

An interview was conducted with the Clinical Reimbursement Consultant on 12/14/2023 at 2:09 PM. The Clinical Reimbursement Consultant revealed she became aware of the inaccurate MDS assessments after running a report on 9/14/2023 and a Performance Improvement Plan (PIP) was developed at that time. The Clinical Reimbursement Consultant explained the MDS nurse was unable to meet the expectations of the PIP and the PIP was modified on 11/30/2023, to include hiring additional MDS nurses to assist with MDS assessments in a timely manner.

The Regional Nurse Consultant was interviewed on 12/14/2023 at 2:54 pm and she reported the facility had received the report from the Clinical Reimbursement Consultant in September 2023 and the facility developed a PIP and the goals were not being met by the MDS nurse, so they modified the plan on 11/30/2023. The Regional Nurse Consultant explained the facility had hired additional MDS nurses to help with the completion of MDS assessments. The Regional Nurse Consultant reported that MDS accuracy was an important factor in resident care.
During an interview with the Administrator on 12/14/2023 at 3:06 PM, he reported he started his position on 9/14/2023 and received the late MDS report from the Clinical Reimbursement

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Consultant. The Administrator explained the facility had an ad hoc Quality Improvement Meeting and developed a PIP, but upon review on 11/30/2023, discovered that the goals were not being met, and the Quality Improvement team developed another PIP.

Nurse #4 was interviewed on 12/14/2023 at 3:41 PM. Nurse #4 reported she was newly hired to assist with the completion of MDS assessments for the facility and she had received education regarding the accuracy of MDS assessments.

The facility plan of correction was reviewed and it read:

On 11/29/2023 the facility identified inaccurately coded MDS assessments. Education was provided by the Administrator to the MDS nurses on MDS accuracy on 12/1/2023. The Administrator or designated manager will monitor MDS assessments weekly for 4 weeks and monthly for 2 months using the Quality Assurance tools to ensure assessments were coded correctly. The reports will be presented to the weekly Quality Assurance meeting by the Administrator or the Director of Nursing. Compliance will be monitored, and an ongoing auditing program will be reviewed at the weekly Quality Assurance meeting. The date of compliance was 12/2/2023.

The plan of correction was validated by review of the education provided, review of the audits completed by the facility, and interview with the newly hired MDS nurse regarding education received and monitoring in place. MDS assessments completed after 12/2/2023 were reviewed for accuracy and no issues were

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F 641	Continued From page 21 identified. The facility date of compliance of 12/2/2023 was validated.	F 641		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to use the services of a Registered Nurse (RN) for 8 consecutive hours per day for 10 of 10 dates reviewed (7/8/23, 7/15/23, 7/22/23, 7/23/23, 8/20/23, 8/26/23, 8/27/23, 9/2/23, 9/3/23, and 9/9/23). The findings included: The Payroll Based Journal (PBJ) data report for fiscal year 2023, the quarter from 7/1/23 to 9/30/23 was reviewed. The report indicated the facility had the following days within the quarter with no Registered Nurse (RN) hours: 7/8/23, 7/15/23, 7/22/23, 7/23/23, 8/20/23, 8/26/23, 8/27/23, 9/2/23, 9/3/23, and 9/9/23.	F 727	Past noncompliance: no plan of correction required.	

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The nursing schedules for 7/8/23, 7/15/23, 7/22/23, 7/23/23, 8/20/23, 8/26/23, 8/27/23, 9/2/23, 9/3/23, and 9//9/23 were reviewed. No RN was scheduled to work on the reviewed dates. The time sheets for 7/8/23, 7/15/23, 7/22/23, 7/23/23, 8/20/23, 8/26/23, 8/27/23, 9/2/23, 9/3/23, and 9//9/23 were reviewed and no RN were documented to have had worked any shifts for the reviewed dates.

During an interview with the Director of Nursing (DON) on 12/13/23 at 12:40 PM she reported she had started her position in May 2023, and she was not aware a RN was to be scheduled to work every day for 8 consecutive hours until September 2023. The DON reported the scheduler had told her there were no RNs available to work those dates, but the DON did not understand the importance of having an RN on the schedule. The DON explained a corrective action plan had been put in place and she was conducting daily audits of the schedule for RN coverage.

An interview was conducted with the Scheduler on 12/14/23 at 11:11 AM. The Scheduler explained the facility used staffing agencies to fill in blank spots in the schedule and on the dates listed above, when she knew there was no RN to work, she had reported to the DON about the lack of RN coverage. The Scheduler explained the schedule was discussed by nursing managers and her every morning. The Scheduler concluded she had received education regarding RN coverage on 11/10/2023 by the Quality Assurance nurse.

The Administrator was interviewed on 12/14/23 at 3:06 PM. The Administrator reported the dates

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without an RN scheduled to work were before he started his position as Administrator, and when he took the position, he received the PBJ report of no RN hours for Quarter 4 of 2023. The Administrator explained a Performance Improvement Plan was developed to prevent a recurrence of no RNs scheduled for 8 consecutive hours per day.

The facility plan of correction was reviewed and it read:

On 11/10/23 the facility identified there were occurrences when there was no RN coverage scheduled. The facility conducted audits and identified 10 days where there was no RN coverage: 7/8/23, 7/15/23, 7/22/23, 7/23/23, 8/20/23, 8/26/23, 8/27/23, 9/2/23, 9/3/23, and 9/9/23. The Quality Assurance (QA) Nurse Consultant in-serviced the Administrator, DON, Assistant DON, and the Scheduler on 11/10/23 regarding RN coverage. The Administrator and QA Nurse will monitor staffing to ensure the facility has RN coverage daily using the Quality Assurance tool for staffing. This would be completed daily for 5 days per week for 4 weeks, and then weekly for 8 weeks. The reports will be presented to the weekly Quality Assurance committee by the Administrator or the DON to ensure corrective action that was initiated was appropriate. Compliance will be monitored and ongoing auditing program at the weekly Quality Assurance meeting, attended by the Administrator, the DON, and other management leaders. The date of compliance was 11/11/23.

The plan of correction was validated by review of the education provided, review of the audits completed by the facility and interviews with the

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F 727	Continued From page 24 DON, Scheduler, and the Administrator. The facility date of compliance of 11/11/23 was validated.	F 727		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on a test tray observation, record review, and resident and staff interviews the facility failed to serve food warm that should be served warm to 1 of 4 halls (300 hall). This practice had the potential to impact other residents. The findings included: 1)Resident #30 was admitted to the facility 3/8/2019. A review of the quarterly Minimum Data Set (MDS) revealed Resident #30 was cognitively intact and had not experienced weight loss. An interview was conducted with Resident #30 on 12/12/2023 at 9:45 a.m. and he revealed the food frequently arrives cold. An observation of the meal tray line service in the kitchen was conducted on 12/13/2023 at 12:31	F 804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F804 1. For dietary services, a corrective action was obtained on 12/11/2023. Based on observation, record review, and resident, staff, and family interviews it was noted the facility failed to provide serve food warm that should be served warm to 1 of 4 halls.	1/5/24

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F 804	Continued From page 25 p.m. The temperatures of the food items of regular and puree consistency were greater than 135-degree Fahrenheit. The food items were placed on heated plates from a plate warner. The plated meals were covered with insulated, dome shaped lids with bottoms. The dome shaped lids did not close completely due to a bowl, containing brussel sprouts that prevented the closer. The Dietary Manager (DM) was observed to provide instructions to the dietary staff to ensure the lids closed. A total of nine plates were observed to be placed on the 300-hall meal cart with the lids opened on the sides. The meals were placed in a four-sided, stainless-steel delivery cart and transported to the 300-hall at 12:52 p.m. where the nursing staff immediately began serving the residents on the 300-hall. A test meal tray of regular and puree textured foods were included in the meal delivery cart. On 12/13/2023 at 1:02 p.m., after the residents of the 300-hall were served, the DM and this surveyor observed the test meal tray for palatability. The lasagna was cool to taste on both test trays and the brussel sprouts were cool on the puree test tray. The DM participated in the testing of the two meal trays and acknowledged these findings. An interview was conducted with Resident #30 on 12/13/2023 at 4:50 p.m. and he revealed his lunch on 12/13/2023 tasted good but it was cold. He added he did not ask anyone to warm up his food because this happens a lot and the Nursing Assistants would be spending all their time warming up meal trays. He stated he had informed staff on many occasions the food arrives cold.	F 804	For Resident #31 and interview took place on 12/12/2023 he revealed the food frequently arrives cold. For resident #31 an interview took place on 12/13/2023 he revealed his lunch on 12/13/2023 tasted good but it was cold. He added he did not ask anyone to warm up his food because this happens a lot and the Nursing Assistants would be spending all their time warming up meal trays. He stated he had informed staff on many occasions the food arrives cold. For resident #47 an interview took place on 12/13/2022 she revealed the lunch tray on 12/13/2023 was cool to the touch and if she could have reheated it, she would have. For Resident #19 an interview was conducted on 12/13/2023 and the Resident stated at lunch the Brussel sprouts were cold. Beginning 1/2/2023, Administrator completed test tray audit x 3 days to ensure holding temperature had been met for meals and reviewed temperature logs to confirm cooking and holding temperatures had been met for meals on 01/03/2024. 2. Corrective action for residents with	

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F 804	Continued From page 26 2)Resident #47 was admitted to the facility on 9/5/2023. A review of the quarterly MDS dated 11/9/2023 revealed Resident #47 was cognitively intact and had not experienced weight loss. An observation of the meal tray line service in the kitchen was conducted on 12/13/2023 at 12:31 p.m. The temperatures of the food items of regular and puree consistency were greater than 135-degree Fahrenheit. The food items were placed on heated plates from a plate warner. The plated meals were covered with insulated, dome shaped lids with bottoms. The dome shaped lids did not close completely due to a bowl, containing brussel sprouts that prevented the closer. The Dietary Manager (DM) was observed to provide instructions to the dietary staff to ensure the lids closed. A total of nine plates were observed to be placed on the 300-hall meal cart with the lids opened on the sides. The meals were placed in a four-sided, stainless-steel delivery cart and transported to the 300-hall at 12:52 p.m. where the nursing staff immediately began serving the residents on the 300-hall. A test meal tray of regular and puree textured foods were included in the meal delivery cart. An interview was conducted with Resident #47 on 12/13/2023 at 3:34 p.m. and she revealed the lunch tray on 12/13/2023 was cool to the touch and if she could have reheated it, she would have. 3) Resident #19 was admitted to the facility on 4/27/2021. A review of the quarterly MDS dated 9/27/2023 revealed the Resident was cognitively intact and	F 804	the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 01/04/2024, the Administrator completed an in-service to discuss dining experience and meal cooking and holding temperatures with dietary staff. Test Trays will be incorporated more often until food complaints reduce or resolve completely. Residents mentioned above will be interviewed and monitored on a regular basis to ensure food delivered is per expectations. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff. Topics included: " Meal objectives and procedures " Test Tray completion " Focus on dining experience Test Trays will be completed to ensure satisfactory dining experience. Dietary Manager will attend resident council as invited and follow up with any food complaints as identified. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any dietary staff who does not receive scheduled in-service training by 01/04/2024 will not	

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F 804	Continued From page 27 had not experienced any weight loss. An observation of the meal tray line service in the kitchen was conducted on 12/13/2023 at 12:31 p.m. The temperatures of the food items of regular and puree consistency were greater than 135-degree Fahrenheit. The food items were placed on heated plates from a plate warner. The plated meals were covered with insulated, dome shaped lids with bottoms. The dome shaped lids did not close completely due to a bowl containing brussel sprouts that prevented the closer. The Dietary Manager (DM) was observed to provide instructions to the dietary staff to ensure the lids closed. A total of nine plates were observed to be placed on the 300-hall meal cart with the lids opened on the sides. The meals were placed in a four-sided, stainless-steel delivery cart and transported to the 300-hall at 12:52 p.m. where the nursing staff immediately began serving the residents on the 300-hall. A test meal tray of regular and puree textured foods were included in the meal delivery cart. An interview was conducted with Resident #19 on 12/13/2023 at 3:34 p.m. and the Resident stated at lunch the brussel sprouts were cold.	F 804	be allowed to work until training has been completed. 4. Quality Assurance monitoring procedure. The Administrator. or designee will complete a test tray Monday through Friday weekly x 2 weeks, then weekly x 2 weeks, and then monthly x 2 months. Monitoring will include reviewing food items for appearance and taste as well as visiting with residents when complaints are received. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manage. Date of Compliance: 01/05/2024	
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	F 812		1/5/24

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F 812	Continued From page 28 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 date and label opened food in 1 of 1 walk in cooler. The findings included: On 12/11/2023 at 10:52 a.m. observations were made of the facility's walk-in cooler with the Dietary Manager (DM). Upon entrance there were the following items without a label or date: A. Sliced ham opened and wrapped in a plastic wrap. B. Two containers of sliced turkey wrapped in a plastic wrap. C. A freezer storage bag with a white chunk of food. This item also did not have an expiration date. During the observation of the walk-in cooler, an interview was conducted with the DM on 12/11/2023 at 10:52 a.m. and she revealed the sliced ham should contain a label and date. She added the two containers of sliced turkey should also contain a label and date. She stated the white substance stored in the freezer bag was	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services; a corrective action was obtained on 12/12/2024. During walk through of the kitchen it was noted the facility failed to date and label opened food in 1 of 1 walk in cooler. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice.	

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F 812	Continued From page 29 cream cheese that had been removed from the original packaging. She stated it was her expectation that every item in the walk in cooler have a label and date when it has been opened. An interview was conducted with the Administrator on 12/14/2023 at 11:01 a.m. and he revealed it was his expectation that all foods in the kitchen be labeled and dated once opened.	F 812	On 12/11/2024, the Dietary Manager discarded all items noted without a date or label from walk in cooler. 2. Systemic changes Beginning 1/3/2024, In-service education was provided to all full time, part time, and as needed dietary staff. Topics included: " Inspections to observe all food are within their dates with label and date displayed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any dietary staff who does not receive scheduled in-service training by 01/04/2024 will not be allowed to work until training has been completed. 3. Quality Assurance monitoring procedure. The Administrator or designee will monitor procedures by completing kitchen inspections weekly x 4 weeks and then monthly x 2 months using the Dietary Quality Assurance Audit. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the	

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F 812	Continued From page 30	F 812	Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager Date of Compliance: 1/5/2024	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		1/5/24

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F 867	Continued From page 31 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health	F 867		

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F 867	Continued From page 32	F 867		

outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data

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F 867	Continued From page 33 resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions the committee had previously put into place following the 5/12/2022 recertification and complaint investigation survey. The deficiencies were in the areas of (F636) Comprehensive Assessments; (F638) Quarterly Assessments at least every three months; (F641) Accuracy of Assessments; and (F812) Food Procurement and Store, Prepare, and Serve Food in a Sanitary Manner. These deficiencies were subsequently recited on the current recertification and complaint survey on 12/15/23. The continued failure during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: The tag is cross-referenced to: F636-Based on record reviews and staff interviews, the facility failed to complete 1 of 4 admission comprehensive Minimum Data Set (MDS) assessments within 14 days of an admission and failed to complete comprehensive MDS assessments within 14 days of the Assessment Reference Date (ARD) [the last day of the assessment period] for 5 of 26 sampled residents. The facility failed to complete an admission Minimum Data Set (MDS) comprehensive	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilitys allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/29/2023 the facilitys Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 7/15/2022 and recertification survey completed on 5/3/21. This was for 4 deficiencies that were cited in the areas of Comprehensive Assessment and Timing (F636), Qrtly Assessment at Least Every 3 Months (F638), accuracy of assessments (F641), and Food Procurement, Store/ Prepare/Serve- Sanitary (F812). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain effective QAA program.	

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F 867	Continued From page 34 assessment within 14 days of the assessment reference date for 2 of 7 residents during a recertification and complaint investigation survey conducted 5/12/2022. F638-Based on record reviews and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments within 14 days of the Assessment Reference Date (ARD) [the last day of the assessment period] for 6 of 21 sampled residents. The facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days of the assessment reference date for 1 of 9 residents reviewed for timeliness completion of quarterly MDS assessments during a recertification and complaint investigation survey conducted 5/12/2022. F641-Based on record reviews and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments for 3 of 26 sampled residents. The facility failed to accurately complete the quarterly minimum data set (MDS) for 1 of 2 sampled residents reviewed for range of motion during a recertification and complaint investigation survey conducted 5/12/2022. F812-Based on observations and staff interviews the facility failed to date and label opened food in 1 of 1 walk in cooler. The facility failed to maintain sanitary conditions in the kitchen and in 1 of 2 nourishment rooms by not ensuring food items were not stored on the floor; by not ensuring resealed food items were dated/labeled; by not ensuring food service	F 867	2. Corrective action for residents with the potential to be affected by the alleged deficient practice: "Corrective action has been taken for the identified concerns in the areas of: Comprehensive Assessment and Timing (F636) "Corrective action has been taken for the identified concerns in the areas of: Qrtly Assessment at Least Every 3 Months (F638) Corrective action has been taken for the identified concerns in the areas of: Accuracy of Assessment (F641) "Corrective action has been taken for the identified concerns in the areas of: Food Procurement, Store/Prepare/Serve-Sanitary (F812) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 1/4/2024 to review the deficiencies from the 12/11/23- 12/15/23 annual recertification survey, CI survey, and reviewed the citations. On 1/ 4 /2024, the Regional Clinical Nurse Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 1/ 4/ 2024 the Regional Clinical Nurse Consultant completed in-servicing with the QAPI team members that include the	

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F 867	Continued From page 35 equipment remained free from debris; and by not ensuring dietary staff wore hair covering while preparing meal trays on the meal tray line during a recertification and complaint investigation survey conducted 5/12/2022. During an interview with Administrator #1 on 12/14/2023 at 3:50 pm he stated he was not the administrator during the 5/12/2022 recertification and complaint investigation survey but the facility had put a plan of correction into place and had worked to improve the areas identified for the Minimum Data Set assessments to be completed timely and accurately since he was hired as the Administrator. The Administrator also stated the storage of food would be addressed by the facility's Quality Assessment and Assurance Committee and the facility would work to improve in that area. The Administrator indicated the facility's Quality Assessment and Assurance Committee was meeting monthly and would continue to improve in the areas of concern.	F 867	Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 1/4/2024. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Regional Director of Operations or Regional Nurse Consultant will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 36	F 867	weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 1/5/2024	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345503	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REHAB CTR OF ROWAN CO	**4412 SOUTH MAIN STREET SALISBURY, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and 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 CMS-10055 (Centers for Medicare and Medicaid Services) Skilled Nursing Facility Beneficiary Notice of Non-coverage (SNFABN) prior to discharge from Medicare part A services to one of three residents (Resident #291). The findings included: Resident #291 was admitted to the facility under Medicare Part A services on 4/7/2023. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter was signed by Resident #291 on 6/22/2023. The notice indicated that Medicare coverage for skilled services ended on 6/21/2023 and the resident would remain in the facility.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345503	A. BUILDING: _____ B. WING _____	12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1 A review of the medical record revealed a CMS-10055 SNF ABN was not provided to the resident until 06/22/2023. An interview was conducted with the Billing Office Manager (BOM) on 12/14/2023 at 2:19 p.m. and revealed Resident #291's Medicare A coverage was to end on 6/21/2023 and this should have been discussed with the Resident on 6/19/2023. The BOM added that she had been off work the day this occurred, and she had discussed it with the Resident upon return on 6/22/2023. An interview was conducted on 12/14/2023 at 11:01 a.m. with the Administrator and he revealed it was his expectation that all required notification forms for exhausted or ended benefits be presented to a Resident or the representative on the dates as required.