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	345097	A. BUILDING _____ B. WING _____	C 12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

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E 000	Initial Comments An unannounced Recertification and complaint survey was conducted on 12/12/2022 through 12/15/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # DV1611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint invesigation was conducted from 12/12/2022 through 12/15/2022. Event ID # DV1611. 3 of 3 complaint allegations were not substantiated. Intake NC00193369.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 645		1/12/23

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

Electronically Signed | 01/06/2023

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F 645	Continued From page 1	F 645		

(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an

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F 645	Continued From page 2 intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to rescreen a resident with diagnoses including mental illness for Level II Preadmission Screening and Record Review (PASRR, a resident identified as having a serious mental illness or intellectual debility and/or developmental disability as defined by state and federal guidelines) for 1 of 3 residents reviewed for Preadmission Screening and Record Review (PASRR) (Resident # 41). Findings included: Resident #41 had been admitted on 06/17/2022 with diagnoses that included epilepsy and schizophrenia. Resident # 41's admission Minimum Data Set (MDS) assessment dated 06/20/2022 did not indicate that Resident # 41 was considered by the state Level ll PASRR process to have a serious mental illness or intellectual disability and /or developmental disability. Review of facility documentation revealed a Level II PASRR evaluation was completed for Resident # 41 on 06/09/2022 and indicated placement had been approved for 90 days with an expiration date of 09/07/2022 and further approval and screening was required within 5 days of the PASRR expiration date by the facility. On 12/13/2022 at 5:45 PM an interview with the Social Worker (SW) was conducted. The SW	F 645	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F645 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #41's PASRR Level ll was submitted for further approval and rescreening on 12/13/2022. On 12/29/2022, the rescreening process was completed, and the resident was issued a halted Preadmission Screening and Record Review (PASRR) number which does not expire. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 1/5/2023 the Administrator audited 100% of residents with Level II PASRR	

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F 645	Continued From page 3 stated that she did not know Resident # 41 had a PASRR Level ll assigned to him on admission to the facility and she was not aware there was a 90-day expiration date, and that further approval and rescreening was required prior to the expiration date of 09/07/2022. The Administrator was interviewed on 12/15/2022 at 2:46 PM. He stated the SW was responsible for obtaining Level ll PASRR status and updating PASRR status as required and communicating PASRR status to members of the interdisciplinary care team.	F 645	and none were found to be expired. On 1/2/2023 an in-service was conducted by the Administrator for staff submitting a PASRR Level II for further approval and rescreening, prior to the expiration date. Any staff members who do not receive the training by 1/8/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Beginning 1/3/2023, the Admissions Director will provide the PASRR number upon a resident's admission, to the facility Administrative Team. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Beginning 1/9/2023, the Administrator and/or designee will audit 100% new admissions for PASRR compliance for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		1/12/23

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F 732	Continued From page 5 by: Based on record review and staff interview, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 3 of 5 posted daily staffing forms reviewed. Findings included: Daily staffing forms for 9/15/2022, 9/16/2022, 10/9/2022, 10/29/2022, and 12/8/2022 were reviewed and revealed the following were not accurate on 3 of 5 dates: a. The nursing schedule for 9/15/2022 had 2 Registered Nurses (RNs) scheduled for 2nd shift (3:00 PM to 11:00 PM). The posted daily staffing form indicated 1.5 RNs provided 12 hours of care on that date for 2nd shift. The nursing schedule for 9/15/2022 had 3 nursing assistants (NAs) scheduled to work the 3rd shift (11:00 PM to 7:00 AM). The posted daily staffing form reported 2 NAs provided 16 hours of care on that date for 3rd shift. b. The nursing schedule for 10/9/2022 had 1.5 Licensed Practical Nurses (LPNs) scheduled to work 2nd shift. The posted daily staffing form indicated 1 LPN provided 8 hours on that date for 2nd shift. c. The nursing schedule for 12/8/2022 had no RN scheduled to work 1st shift (7:00 AM to 3:00 PM), 3 LPN scheduled to work, and 4 NAs scheduled to work. The posted daily staffing form reported 1 RN provided 8 hours of care, 2 LPNs provided 16 hours of care, and 6 NAs provided 48 hours of care. The nursing schedule for 2nd shift on 12/8/2022 had 1.5 RNs, 2.5 LPNs, and 3 NAs scheduled to work. The posted daily staffing form	F 732	F732 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; No residents were noted to be affected by not updating the daily posting with staffing changes. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; No potential residents were noted to be affected by not updating the daily posting with staffing changes. On 1/3/2023, an in-service was conducted by the Nurse Educator for staff posting accurate staffing information for licensed and unlicensed nursing staff. Any staff members who do not receive the training by 1/8/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Beginning 1/9/2023, the charge nurses	

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F 732	Continued From page 6 indicated 2 RNs provided 16 hours of care, 1.5 LPNs provided 12 hours of care, and 4 NAs provided 32 hours of care. The schedule for 3rd shift on 12/8/2022 had 1 RN scheduled to work, 2 LPNs, and 1 NA was leaving early at 5:30 AM. The posted daily staffing form indicated 2 RNs provided 16 hours of care, 1 LPN provided 8 hours of care, and 4 NAs provided 32 hours of care for that shift. The Director of Nursing (DON) was interviewed on 12/15/2022 at 2:49 PM. The DON reported she was responsible for scheduling the nurses and NAs, and she was also responsible for the posted daily staffing form. The DON explained that the charge nurses would update the posted daily staffing sheet during 2nd and 3rd shift for any changes in staffing. The DON reported that a lot of call outs or schedule changes made it difficult to keep an accurate posted daily staffing sheet. The Administrator was interviewed on 12/15/2022 at 3:12 PM. The Administrator reported it was his expectation that the daily posted staffing sheet was updated with any staffing changes to accurately reflect the current staffing in the facility.	F 732	will update the posted daily staffing sheets to reflect changes in staffing and/or census. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Beginning 1/9/2023, the Director of Nursing and/or designee will weekly audit 3 daily staffing forms for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	
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	F 812		1/12/23

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F 812	Continued From page 7 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, record review and staff interview the facility failed to remove dry goods stored past the use by date and ensure all dry goods stored ready for use had use by dates, failed to remove scoops with the handles resting in ingredients from four of four dry storage bins, failed to clean silverware intended for the lunch meal for one of one silverware tray, failed to label a container of ice cream in the reach in freezer and failed to label and dispose of one of one expired food products in a resident community refrigerator. The findings included: 1. An initial observation of the off-site kitchen conducted on 12/15/22 from 9:50 AM to 10:44 AM with the Dietary Manager (DM) revealed the following opened dry storage items without a date to indicate how long the items was good for: - a 22.6 oz. opened package of chicken gravy mix best by October (unable to see the year) 1/8 bag left. - a 26.5 oz bag opened package ¼ full of instant potato pearls best by June 4, 2022.	F 812	F812 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; All items identified by the surveyor as being improperly labeled and/or expired, were discarded. On 12/12/2023 the use by dates were added to the dry goods stored ready for use and the scoops were properly placed in the dry storage bins. In addition, on 12/13/2022, all the silverware was properly cleaned. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 12/13/2022 all dietary staff was in-serviced by Food and Nutrition Director on removing dry goods by the use by date, ensuring dry goods stored ready for	

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F 812	Continued From page 8 - a 1 pound box of corn starch, ¼ of the box left. The manufactures label was ripped off the cardboard making it unreadable. 2. An observation during the initial kitchen tour on 12/15/22 from 9:50 AM to 10:44 AM with the DM revealed the scoops were left inside the flour, rice and sugar bins. The scoop and handle were lying in the flour, sugar and brown and white rice. During the initial tour the DM stated that the scoops should be kept on the dry rack and cleaned after each use. 3. An observation of the service kitchen (a small kitchen which is used to serve, not prepare food) at the facility on 12/15/22 from 11:22 AM - 11: 45 AM was conducted. A clean tray of silverware intended for the lunch meal service revealed white paper on 2 forks, one spoon had a dried yellow dot, one spoon appeared dirty with streaks on it and one fork had a dried brown dot on it. An interview on 12/15/22 at 11:35 AM with the Dietary Assistant (DA) confirmed the silverware in the tray was clean and removed the dirty silverware. An observation of the reach in freezer in the service kitchen at the facility revealed a 3-gallon container of ice cream was not labeled with an open date. The container was ¾ full. An interview on 12/13/22 at 2:45 PM with the Dietary Supervisor (DS) stated that she had sent the tray back to the main kitchen and has had to send silverware back approximately once every 2 weeks. The DS stated that they roll the silverware in a napkin to go on the resident tray and it is inspected, and no residents had received dirty silverware. The DS stated the container of ice cream that was in the reach in freezer is from the activities department and the Activity Director	F 812	use are labeled with use by dates, ensuring scoops with the handles are not resting in ingredients in dry storage bins, and properly cleaning silverware intended for the meal service. Any staff members who do not receive the training by 1/8/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 12/16/2022 the Activity Coordinator was in-serviced by the Administrator on labeling containers of ice cream in the reach in freezer and labeling and disposing of expired food items in the resident community refrigerator. Any staff members who do not receive the training by 1/8/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 1/4/2023 the Night Charge Nurses were in-serviced by the Administrator on labeling and disposing of expired food items in the resident community refrigerator. Any staff members who do not receive the training by 1/8/2023 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Address what measures will be put into	

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F 812	Continued From page 9 (AD) should be labeling their ice cream container when it was opened. 4. A observation of community refrigerator in the television room on 12/13/22 at 3:23 PM was conducted. The refrigerator had a sign on the front that read 'For resident and family use only'. Inside the refrigerator was a double bagged package that contained a package of bratwurst with a best by date of 12/8/22. The outside of the package had the residents name and room number but no date. An interview with Nurse #1 on 12/13/22 at 3:24 PM who was shown the bratwurst and stated the residents name and date should have been on the package. An interview with the Director of Nursing (DON) on 12/13/22 at 3:27 PM who confirmed there was no date, and the bratwurst were expired. The DON stated that several people rotate cleaning out the refrigerator such as the night shift nurse and the Activities Coordinator. An interview on 12/13/22 at3:47 PM was completed with the Administrator who stated that the Activities is the person responsible for cleaning out the resident refrigerator. The Administrator stated he cannot understand why their would-be raw meat in the refrigerator as there is nowhere for meat to be cooked at the facility. An interview was completed with the DM on 12/14/22 at 9:03 AM who stated that once a product is opened it should have a label that states the opened date and the use by or expiration date. The DM stated that silverware	F 812	place or systemic changes made to ensure that the deficient practice will not recur; Beginning 12/14/2022 the process for the physical sorting of the silverware was changed to ensure all silverware was cleaned prior to reaching the facility. Beginning 12/30/2022 all teammates will utilize the label machine to generate the correct expiration dates for food items. Beginning 12/29/2022 the Production Supervisor will add twice daily checks for compliance with proper storage of scoops and utilizing the closing checklist. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Beginning 1/9/2023, Food and Nutrition Senior Director and/or designee will audit dry goods items being properly labeled and discarded if expired, scoops properly placed in the dry storage bins, and properly cleaned silverware for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Beginning 1/9/2023, Administrator and/or designee will audit food items in the	

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F 812	Continued From page 10 gets cleaned at the off-site kitchen and then transported back 6 times a day to the facilities service kitchen and explain that we are not watching as close as possible and miss seeing some of the dirty silverware. The DM stated that in her opinion a spoon could be lying on top of another spoon and not get cleaned as well as it should. The DM stated that it is her expectation that we would be doing all the necessary things such as ensure the silverware is clean, items are labeled and dated properly, and scoops are stored properly. An interview was completed with the Administrator on 12/14/22 at 4:44 PM who stated that he would expect that there are no items in the refrigerator or freezer that have been opened with no labels or dates.	F 812	resident refrigerator for proper labeling and discarded if expired and labeling of ice cream in the walk-in freezer for 12 weeks. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Director of Nursing on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. POC Completion Date will be 1/12/2023	