STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345004	A. BUILDING _____ B. WING _____	C 08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSON MEMORIAL HOSPITAL	615 RIDGE ROAD ROXBORO, NC 27573

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E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		10/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2023

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

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to maintain and update the EP plan, update for current contacts, address EP collaboration, collaborate with local stakeholders, update, or review for arrangements with other facilities, review and update the communication plan, update names and contact information, share information with residents or family members, put into place EP training, and document information in the EP regarding the emergency generator. This failure had the potential to affect all residents. The findings included: A review of the facility's Emergency Preparedness (EP) Plan occurred on 8/23/23 at 2:35 PM, with the Administrator. During the review, it was discovered the emergency plan had not been updated since 3/2021. Emergency contact information, risk assessment, communication systems, annual training or required exercised for staff on the EP plan at this facility had not been updated since 3/2021. The Administrator stated some sections of the EP plan had been updated but not all and all staff , including new hire training had not been trained on the emergency plan.	E 004	Person Memorial Hospital acknowledges the receipt of the Statement of Deficiencies and the proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality care for the residents. The plan of correction is submitted as a written allegation of compliance. Personal Memorial Hospitals response to the Statement Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency in accurate. Further, Person Memorial Hospital reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through the informal dispute resolution, formal appeal procedures, and/or other administrative or legal proceedings. It is the policy of the Facility to develop a Emergency Plan and maintain an updated plan. Person Memorial Hospital manages the Emergency Plan for the Extend Care Unit located in the hospital on the 2nds floor .	

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E 004	Continued From page 2 An interview was conducted on 8/23/23 at 2:35PM. The Nursing Home Administrator (NHA) explained he was new to the facility and was unaware the EP manual had not been updated in the last 12 months. The NHA stated he started April 2023, and he expected the EP manual to be updated annually to include staff training and exercises as required. NHA stated he had not completed the risk assessment form or directly trained the staff on how to use the EP plan/program. He explained he would be developing systems to ensure all staff are trained in the content of the program and how to utilize the program in an event of emergency on the Extended Care Unit.	E 004	Upon being noticed that the signature sheet for update was not located in the current binder on the floor the Administrator notified the Acute Administration and ensured the contact phone number was up to date for for ECU management staff. The Hospital Emergency Preparation Committee met on June 23,2023 and had approved the updates for the plan. The plan was to be implimented July 2023. The New updated Plan was placed in the ECU binder 9/13/23 ECU administrator will now attend the Hospital Emergency Plan committee meeting quarterly to report and monitor any new changes to plan. On 9/7/23 Administrator at Staff Meeting reviewed that the Emergency Plan binder was located at the Nursing Station in the cabinet above the sink. Reminded staff of the location of the emergency water and slide for resident transport down stairs in O2 closet. ECU staff to be in-serviced on details of the Emergency Plan and location of the binder. By Adm by 10/8/23. Emergency Plan Binder will be updated with new management contact numbers and be checked monthly and reveiwed at QAPI 3x months. To be monitored by Adm, DON on rounds to ensure in place at nursing station and random questions to staff for location at staff meetings; 3x and then quarterly ongoing .	
F 000	INITIAL COMMENTS A recertification and complaint investigation	F 000		

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F 000	Continued From page 3 survey was conducted from 8/20/23 through 8/23/23. Event ID# 34TH11. The following intake was investigated: NC00195216. 4 of the 4 complaint allegations did not result 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. (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	F 565		10/8/23

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F 565	Continued From page 4 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 resident and staff interviews and review of resident council minutes, the facility failed to provide regular resident council monthly meetings (February 2023, March 2023, April 2023, and May 2023) for 4 consecutive months. The findings included: Review of resident council meeting minutes revealed no evidence that resident council meetings were conducted from February through May 2023. The resident council meeting was held on 8/22/23 at 2:00 PM. There were 10 residents identified as alert and oriented who participated in the meeting. The members of the group reported they were regular attendees of the resident council meetings. The residents reported the facility did not have any activity staff for four months to hold resident council meetings (February through May 2023). An interview was conducted on 8/22/23 at 4:00 PM with the Activity Director. The Activity Director stated she started working in the activities department in June 2023. The Activity Director further stated there was no documentation resident council meetings were held from February 2023 through May 2023. During an interview conducted on 8/22/23 at 4:30 PM the Administrator confirmed there were no resident council meetings held for residents per	F 565	It is the policy of the Facility to assist Resident/Family Groups to gather and organize and to assist in the making residents and family members aware of meeting in a timely manner. Facility also will provide a designated staff person approved by the group to assist. Resident concerns were identified through the grievance process for the facility by SS and staff and handled per the system. Upon the arrival of the new Administrator (4/24/23)it was noted the current AD at the time was not a certified Activities Director of held formal education had no training to qualify for the role. Current AD at that time was given the opportunity to get credentials but was not able to comply. Administrator worked with HR to recruit for a credentialed AD for the facility in May of 2023. A new AD was secured for the role who was credentialed and started 6/5/2023. Resident Council President was aware of no actual meeting for, May 2023 and was Ok to hold council meeting until next month(June); with the start of new AD in June 2023. The new AD after employment , reviewed systems in the Activities Department and started planning for appropriate events and activity groups. Resident council meetings were to be reorganized; meeting were held on; June 28,2023 , July 26,2023 , and August 30,2023.	

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F 565	Continued From page 5 record review from February 2023 through May 2023. The Administrator further stated he assumed the position April 2023 and had difficulty hiring the proper activity staff to ensure resident council meetings were being held. He stated he would be hiring an activity assistant and ensure resident council meetings were being held monthly. The Administrator was unaware of who was responsible for conducting the meetings before the Activity Director returned in June 2023.	F 565	September Resident council meeting is scheduled for September 26,2023 and is on going. Meetings are noted on monthly Activities Calendar which is distributed to residents and staff and posted on board in the hallway for public view. What is noted in Resident Council Meetings minutes will be on -going an reviewed/ monitored by AD and Administrator for compliance monthly. AD will as required, submit Resident Council Meeting notes to Administrator for review and will follow the implemented practice of facility for any follow up with concerns as mention in the monthly meetings. To be monitored monthly by Adminstrator or DON for completion of the meeting as evidence by written minutes of the meeting occurance. Monthly Resident Council minutes will be submitted each month at QAPI for review x3 an ongoing as needed for further reviews by Administrator and QAPI Team.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §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	F 636		10/8/23

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F 636	Continued From page 6	F 636		

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 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.

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F 636	Continued From page 7 (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 review and staff interviews, the facility failed to complete Minimum Data Set (MDS) assessments within the regulated time frame for 2 of 8 reviewed for resident assessment (Resident # 63, and Resident # 210). Finding included: 1.Resident #63 was admitted to the facility on 8/3/23 with diagnoses that included heart failure and depression. A review of Resident #63's admission MDS assessment dated 8/10/23 revealed the MDS was incomplete and was still in progress as of 8/22/23. The admission MDS assessment was due on 8/16/23. Review of the discharge return not anticipated MDS revealed the Resident #63 was discharged on 8/23/23. During an interview on 8/22/23 at 2:55 PM, the MDS Nurse stated she was hired on 8/14/23 and was in the process of completing all pending and incomplete MDS assessments. She indicated the assessments should be completed within 14 days from the admission date.	F 636	F636 It is the policy of the facility to perform an comprehensive, accurate, standardized reproducible assessment of each resident/s functional capacity. Resident had timely care plans in place but had not been submitted by previous agency MDSC. No resident care was affected by untimely submissions. MDSC to audit open MDS's and to obtain a current list of all outstanding assessments. MDSC worked with PCC consultant to gather necessary data to submit. This was started immediately on 8/22/23. MDSC will complete incomplete assessments by 9/30/23. This will be reviewed by DON and progress will be reviewed with QAPI monthly times 3 months and will review for any further corrective action needed.	

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F 636	Continued From page 8 During an interview on 8/23/23 at 6:06 PM, the Administrator stated the MDS assessments should be completed and transmitted within the time frame as indicated. The Administrator indicated the facility had hired agency staff to complete MDS assessments. He stated he was in the process of directly hiring a MDS Nurse for the facility. 2.Resident #210 was admitted to the facility on 8/1/23 with diagnoses that included chronic pulmonary edema and hypothyroidism. A review of Resident #210's admission MDS assessment dated 8/6/23 revealed the MDS was incomplete and was still in progress as of 8/22/23. The admission MDS assessment was due on 8/14/23. During an interview on 8/22/23 at 2:55 PM, the MDS Nurse stated she was hired on 8/14/23 and was in the process of completing all pending and incomplete MDS assessments. She indicated the assessments should be completed within 14 days from the admission date. During an interview on 8/23/23 at 6:06 PM, the Administrator stated the MDS assessments should be completed and transmitted within the time frame as indicated. The Administrator indicated the facility had hired agency staff to complete MDS assessments. He stated he was in the process of directly hiring a MDS Nurse for the facility.	F 636		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing	F 640		10/8/23

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F 640	Continued From page 9	F 640		

requirement-
§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an

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F 640	Continued From page 10 initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to transmit Quarterly and Annual Minimum Data Set (MDS) assessments within the required time frame for 6 of 8 residents (Resident # 45, Resident # 44, Resident #19, Resident #24, Resident #46, and Resident # 49) reviewed for Resident Assessments. Findings included: a. Resident #45 was admitted on 3/31/21. A review of resident's most recent MDS assessment revealed an Assessment Reference Date (ARD) of 7/5/23 and was coded as a quarterly assessment. The MDS was completed on 7/19/23 and indicated as accepted on 7/24/23. b. Resident #44 was admitted on 3/10/21. A review of resident's most recent MDS assessment revealed an ARD of 7/12/23 and was coded as a quarterly assessment. The MDS was completed on 7/21/23 and indicated as accepted on 7/25/23. c. Resident #19 was admitted on 7/31/19. A review of resident's most recent MDS	F 640	F640 It is the policy of the facility to encode/transmit a resident's assessment within 7 days after completing a residents assessment. MDSC obtained active status with CMS which allowed her to transmit/export ready assessments. Active status was obtained on 8/21/23. MDSC will audit non-transmitted assessments to obtain a current list of non-transmitted assessments as well as the reason assessments were not transmitted. The current MDSC had remote zoom call with consultant for further education. Findings indicated that prior MDSC marked numerous assessments as accepted when they had not been transmitted. Audit of non-transmitted assessments was completed on 8/21/23. MDSC followed PCC guidelines to remove accepted status, unlock and relock to obtain an export ready status. MDSC transmitted all previously non-transmitted assessments. Once transmitted a validation report was reviewed and assessments were accepted the status was changed to accepted status in PCC. Completed 8/31/23. MDSC will transmit all assessments indicated as export ready at	

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F 640	Continued From page 11 assessment revealed an ARD of 7/12/23 and was coded as a quarterly assessment. The MDS was completed on 7/24/23 and indicated as accepted on 7/25/23. d. Resident #24 was admitted on 3/20/23. A review of resident's most recent MDS assessment revealed an ARD of 7/18/23 and was coded as a quarterly assessment. The MDS was completed on 7/18/23 and indicated as accepted on 7/24/23. e. Resident #46 was admitted on 5/20/21. A review of resident's most recent MDS assessment revealed an ARD of 7/13/23 and was coded as an annual assessment. The MDS was completed on 7/24/23 and indicated as accepted on 7/25/23. f. Resident #49 was admitted on 12/30/21. A review of resident's most recent MDS assessment revealed an ARD of 7/7/23 and was coded as a quarterly assessment. The MDS was completed on 7/19/23 and indicated as accepted on 7/24/23. Review of the national database revealed there were no MDS assessments transmitted in July 2023. The last batch of records transmitted was on 6/30/23 when 20 MDS assessment were transmitted. The MDS assessments were not transmitted to the national database. However, were marked as accepted on the facility electronic medical records software. During an interview on 8/22/23 at 2:55 PM, the	F 640	least weekly to ensure compliance. This is ongoing. DON will continue to monitor weekly. A full-time MDS has been hired and start date will be 10/12/23. This will be reviewed at QAPI monthly times 3 and any further corrective action will be reviewed.	

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F 640	Continued From page 12 MDS Nurse stated she was hired on 8/14/23 and did not have access to the national database. She stated she was unable to know why these records, or any records were not transmitted since 7/1/23. During an interview on 8/23/23 at 6:06 PM, the Administrator stated the facility had hired agency staff to complete MDS assessments. The Administrator further stated when one agency staff left on 6/30/23, a new agency staff was hired between 7/9/23 and 7/10/23 to complete the residents MDS assessments. The Administrator stated he was unsure why the agency MDS Nurse had marked these assessment as accepted prior to getting confirmation from the national database that these assessments were transmitted. He added he was unclear as to why these MDS assessments were not transmitted and marked as accepted on the facility medical record software. He added he had no access to the national database and could not tell if these records were transmitted or not. The Administrator stated he was in communication with the agency / contract services as to why these records were not transmitted. The Administrator indicated all MDS should be completed on time and should be transmitted on time.	F 640		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		10/8/23

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F 679	Continued From page 13 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide an on-going activity program that met the individual interests and needs to enhance the quality of life for 1 of 2 residents reviewed for activities (Resident #45). The findings included: Resident #45 was admitted to the facility on 3/31/21. The diagnoses included cognitive and communication deficits. The annual Minimum Data Set (MDS) dated 4/5/23 coded Resident #45's cognition as moderately impaired. The resident's activity preferences indicated the following were very important: religious services, going outside for fresh air, listening to music, keeping up with the news and being around animals. He was also coded for total assistance with transfers and locomotion. The activity assessment completed by the former Activity Director, Activity Director #2, dated 4/5/23 revealed Resident #45's preference in group activities with interest in religious devotion, music, sports, bingo, community outings, pet therapy outdoor activities, current events, movies, and social events. On 8/23/23 at 10:00 AM a phone interview was attempted with the former activity director, Activity Director #2, who completed Resident #45's most	F 679	It is the policy of the facility to provide residents a choice of activities based on their interests to support their physical , mental and psychosocial well-being and encourage independence and interaction in their community. The former AD was not credentialed and the new Administrator upon hired (4/24/23) worked to address the knowledge of the person who was acting as the AD at that time. New AD was hired who was credentialed and had SNF experience and started 6/5/23. The New AD quickly revamped the activities offered and started a review of the residents profiles and preferences for activities. At the time of the survey the AD was in the process of doing the updates for Long term residents in the facility as their as their MDS came due. AD had also had assessed residents for activity involvment and was working to provide actvities the residents choose or prefered. Activity calendars were developed monthly to support resident choices for activities; outdoor and outings were re-established as option for residents to enjoy. AD , was contacting volunteer groups to reestablish relationships with the community and provide events and interactions with-in the ECU. Per policy	

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F 679	Continued From page 14 recent activity assessment. She was unable to be reached. The care plan related to activities for Resident #45 dated 4/5/23 revealed conflicting information with the activity assessment of the same date (4/5/23). The care plan identified the problem as Resident #45 has little or no activity involvement related to disinterest, resident wishes not to participate. The goal included the resident would express satisfaction with type of activities and level of activity involvement when asked. The interventions included staff would explain to Resident #45 the importance of social interaction, leisure activity time. Encourage the residents' participation by talking about the activities allocated for the day. Remind the resident he may leave activities at any time and is not required to stay for entire activity. The resident prefers the following radio stations: Oldies and Gospel. The resident prefers the following TV channels: Westerns. A review of Resident #45's record from 4/5/23 through 8/19/23 revealed no evidence of the resident attending any activities. Review of the activity calendar for Sunday 8/20/23 revealed the only activity noted was "independent activities". On Sunday, 8/20/23, Resident #45 was observed in bed in his room watching television during the following times: 9:00 AM, 10:30 AM, 1:00 PM, and 2:30 PM. Review of the activity calendar on 8/21/23 indicated the following activities were listed: 10:00 AM coffee hour, 11:00 AM gospel hymns, and 2:00 PM activity of choice.	F 679	volunteers needed screening and orientation prior to assisting. Local groups were being scheduled for weekend times to provide community based interactions. Facility AD and Administrator reviewed programs and worked to meet the interests of residents'. With low applications for a Activities Assistant AD and administrator sought alternative staffing to assist with providing resident various actvities. AD worked extra hours and a CNA who was trained in activities also provided services to residents. Administrator had been reviewing the job description with Corporates HR for an assistant. Ad was approved and will be posted by 10/8/2023 AD will review monthly in Resident Council the activities calendar an ask residents about events and activities they wish to participate in. Staff were educated on offering residents activities and to assist to get to the activity in the ECU. by Administrator at Staff meeting held on 9/1/23. DON provided in-service and education to Charge Nurses on 9/14/23 on offering Residents the choice and option to attend activities. AD will ensure activities calenders are posted in the resident rooms and that Public wall calander is current and up to date. AD will also work with CNA's to notify them of actvites for residents to attend of their preference. Resident participation will be montiored by Charge Nurse on unit daily and CNA will encourge residents to partipate in activies of their choice and assist in residents	

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F 679	Continued From page 15 Observation was conducted of Resident #45 on 8/21/23 at 11:00 AM, the time that the activity of gospel hymns was scheduled. Resident #45 was in his room and staff were observed passing by the resident's room and did not stop to offer the resident assistance to participate in the scheduled activity. During an interview and observation on 8/21/23 at 11:10 AM, Resident #45 was observed in bed humming some church songs in his room. He stated he really loved church services and music and food parties the facility had down in the activity room. He indicated no one came to and get him out of bed anymore for activities. He stated he could not take himself to activities without assistance so just ended up hanging out in bed. Resident #45 further stated he just hummed his favorite songs. A telephone interview was conducted on 8/21/23 at 1:57 PM with Resident #45's responsible person. The responsible person stated she would like for the resident to participate in more activities and had been told by staff (no name or date was identified) when she called to check on Resident #45 that he participated in activities in the past. She explained that she had not seen him out of bed much lately during her visits in the past two months. She stated he may or may not want to participate but was not certain how often he was even asked. She further stated he loved church and food related things/activities. He liked to socialize with other people. Observation and interview were conducted on 8/21/23 at 2:30PM and revealed Resident #45 remained in bed watching television. Resident #45 stated he would like to participate in activities	F 679	attendance. To be monitored by Charge Nurses, DON , SS and Admin. on daily rounds of unit. Activities projected calendars for up coming month will be reviewed at current month QAPI for 3x months and then on-going as needed Administrator and AD will actively recruit for Assistant Activities person to cover weekends evening events. Recruitment process will be monitore/ reviewed weekly at ECU staffing review meeting weekly until assitant is hired	

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but staff did not get him out of bed and he would have loved to see what was going on. He indicated staff had not asked if he wanted to attend any activities today.

The activity calendar on 8/22/23 indicated the following activities were listed: 10:00 AM sittercise (sitting exercise), 10:30 AM bible trivia, 11:00 AM reminisce and 3:00 PM bingo.

Observations on 8/22/23 of Resident #45 were conducted during the timeframes of each of the following activities: 10:00 AM sittercise, 10:30 AM bible trivia, 11:00 AM reminisce and 3:00 PM bingo. Resident #45 was observed in bed during each of the activities. Staff were observed walking past the resident's room.

An interview was conducted on 8/22/23 at 1:22PM, Nurse Aide #3 who was assigned to Resident #45. She stated she did not get the resident up for any activities on 8/22/23 because she was busy with other responsibilities. She added Nurse Aides were responsible for asking the residents if they wanted to attend activities and get them ready. Nurse Aide#3 stated when she had a few minutes, the resident would be taken to the activity room. Nurse Aide #3 indicated she was aware Resident #45 liked to participate in activities.

An interview was conducted with Nurse Aide #5 on 8/22/23 at 2:30 PM. Nurse Aide #5 stated the assigned nurse aide should offer their residents the opportunity to get up and go to the activities of the day. Nurse Aide #5 stated the independent activities were of the resident choice on the weekend. Nurse Aide #5 further stated when there were activities of choice, the residents do

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what they want. Nurse Aide #5 further stated Resident #45 does like to attend activities and she was not assigned to Resident #45 on 8/22/23 and did not offer to take the resident to any activities today.

An observation was conducted on 8/22/23 at 3:00 PM of bingo progress as indicated on the activity schedule. Resident #45 was not observed in the activity.

An interview was conducted with the current activity director, Activity Director #1 on 8/22/23 at 11:00 AM. She stated she previously was the activity director at the facility and had left for several months prior to returning to the position in June 2023. She revealed upon her return she discovered there were no activity notes completed, there were incomplete resident assessments for activity preferences and there were limited activities during the week and weekends. Activity Director #1 stated she had worked with Resident #45 in the past and knew Resident #45 enjoyed and participated in religious activities, food activities and social events. She stated because she conducted the activities herself, she could not bring everyone down to the activity room and leave the other residents unattended in the room. Activity Director #1 added the expectation was for the nurse aides to assist bring residents to the activities. Activity Director #1 confirmed when she returned to the position in June of 2023, Resident #45 did not have any documentation that he participated in group activities or received any 1:1 activities of his preference. She further stated she did not have any documentation of activities that were done February 2023 through May 2023 for Resident #45. She stated since she returned, the

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F 679	Continued From page 18 activity calendar included more activities during the week and on the weekends. An interview was conducted with the Director of Nursing (DON) on 8/22/23 at 2:40 PM. The Director of Nursing stated she had only been working in the facility two weeks. The Director of Nursing indicated she was not aware of an issue with residents being asked if they wanted to participate in activities. The Director of Nursing stated all residents should be offered 1:1 and group activities daily and nurse aides should assist residents to activity. The Director of Nursing reviewed Resident #45's activity assessment done on 4/5/23 with the resident's preferences and confirmed Resident #45 should have been offered to participate in the activities that were offered on the schedule available based on Resident #45's preferences. An interview was conducted on 8/22/23 at 4:30 PM, the Administrator stated he began working at the facility April 2023 and was aware the activity program was not "fully operational". He explained there was a lack of programing for resident activities during the week and weekends, inconsistent completion of activity assessments/preferences and no quarterly documentation of resident participation in activities. He was currently in the process of revitalizing the entire program with the hiring of the recent activity director, Activity Director #1, in June 2023 and activity assistant will be hired in the near future to create a more effective program for all residents during the week and weekends. He indicated There was no start date identified for the activity assistant.	F 679		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		10/8/23

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F 727	Continued From page 19 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 review and staff interviews the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours (hrs.) a day for 1 of 30 days reviewed. (7/23/23). Findings included: Review of the facility daily staffing schedules from 7/20/23 through 8/20/22 revealed the following: On 7/23/23 the staffing sheets indicated the facility census was 54 and "0" (zero) RN on duty. During an interview on 8/22/23 at 11:00 PM, the staff scheduler stated on 7/23/23 there was no RN assigned to the building, however she was made aware that if there was no RN on the schedule then the hospital RN supervisor would be counted as the RN for the nursing home. During an interview on 8/22/23 at 4:00 PM, The	F 727	F727 It is a policy for the facility to have a staffed RN for at least 8 consecutive hours a day. The facility DON immediately reviewed the rest of the schedule to ensure there was at least 8 consecutive hours of coverage by a Registered Nurse. On 7/23/23 there was no RN coverage in the building, there were no residents to be affected at that skill level during this time. The facility attempted to find coverage but due to shortages were unsuccessful. The hospital does have an RN supervisor that is available to the ECU in case of an emergency. The scheduler had been instructed by DON and Administrator on 8/22/23 that an RN must be available 8 hours a day. If unable to find coverage they are to notify DON and Administrator to assist with coverage. All RN's employed and the scheduler were in	

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F 727	Continued From page 20 Director of Nursing (DON) stated when she was hired, she was informed that the hospital RN supervisor could be counted as the RN for the facility when there was no RN on the schedule. On 8/23/23 at 12:25 PM, the DON gave the surveyor the Job description for Person House Supervisor RN (Hospital). In the document the following was highlighted and read as follows. "Nursing care: Demonstrate necessary skill and knowledge to provide care for patients according to division/unit specific competencies. Provide personal patient care to provide comfort and wellbeing to patient, acknowledging physiological and psychological needs." The DON stated based on the Hospital RN supervisor job description, the Hospital RN supervisor was responsible for the nursing home when there was no RN scheduled for the nursing home. During an interview on 8/23/23 at 5:30 PM, the Administrator stated there was a RN supervisor in the hospital and her job description indicated she would overlook both Hospital and Nursing home when there was no RN scheduled.	F 727	serviced by the Director of Nursing that there must be 8 consecutive hours a day for 7 days a week of Registered Nurse coverage. This in-service took place on 8/22/23. DON and administrator are to ensure that there is 8 consecutive hours for 7 days a week of RN coverage. Facility is actively recruiting RN staffing. This will be an ongoing audit and all results of audit will be reviewed at QAPI meetings monthly for 3 months. At the end of 3 months QA will review the need for any further actions.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to	F 730	It is the policy of the facility to show	10/8/23

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F 730	Continued From page 21 complete performance evaluations of nurse aides at least once every 12 months and provide in-service education based on the outcome of these reviews for 2 of 2 Nurse Aides (NA) (NA #3 and NA #5). The findings included: During an interview on 8/23/23 at 10:00 AM, NA #3 stated she was hired 4 years ago. NA #3 stated she does not recollect having any performance evaluation for a long time. During an interview on 8/23/23 at 10:30 AM, NA #5 stated she was hired 5 years ago. NA #5 indicated she does not recollect any performance reviews completed annually. During an interview on 8/23/23 at 11:02 AM the Human Resource Staff (HR) stated the staff performance reviews were conducted by the appropriate department. The HR department did not maintain these files. On 8/23/22 at 4:50 PM, the Director of Nursing (DON) and Unit Manager were interviewed. Both DON and Unit Manager indicated they were unsure how staff performance was reviewed or assessed annually. The DON stated she was unable to find any documentation related to annual performance review or any education based on the annual reviews. The DON stated she would be working with the hospital education department to ensure that annual performance reviews were completed for all staff and appropriate education was provided based on these reviews. During an interview on 8/23/23 at 5:30 PM, the	F 730	regular in-service education and annual reviews for CNA's. There is currently no SDC in place but an ad was placed on 9/5/23 to work to fulfill this need. CNA education is being reviewed to ensure that the required education and annual performance reviews will be provided and completed. Employee evaluations are also monitored through an electronic education system provided through the hospital system. Administrator and DON are working with the acute hospital educator to provide appropriate online classes to meet SNF requirements for annual educations. The facility administration has reviewed and is aware of the required education to be provided yearly.Administrator and DON are working with the acute hospital educator to provide appropriate online classes to meet SNF requirements for annual educations. LCSW is working to provide dementia training by 9/30/23. Tracking logs for in-services have been created to track yearly education requirements. Once an accredited DSD has been hired they will assume the responsibiltiy of the education monitoring. Director of Nursing or designee will ensure annual performance reviews are completed. Director of Nursing will review the findings with QAPI monthly x 3 and will review any further corrective action needed.	

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F 730	Continued From page 22 Administrator stated he does not have any nursing degree and the performance review for NA's should be completed by the nursing department. Education and training should be based on these reviews.	F 730		
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.	F 732		10/8/23

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F 732	Continued From page 23 §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 by: Based on observation and staff interviews, the facility failed to post the daily nurse staffing information to residents and visitors for 2 of the 4 days of the survey period. Finding included: On 8/20/23 during facility initial tour and multiple observations throughout the day including at 9:20 AM and at 1:30 PM, the daily nurse staffing sheet posted near the facility elevator was dated 8/18/23. The posting was not updated to reflect the current date, census, and staffing information. On 8/21/23 multiple observations at 9:00 AM; 12:45 PM and 3:30 PM revealed no daily nurse staffing information was posted near the elevator. During an interview on 8/22/23 at 10:20 AM, the Unit Secretary stated she was responsible for completing the staffing information, once she receives the information of assigned staff from the scheduler. The sheets were displayed beside the elevator. The Unit Secretary indicated on Fridays she completed the staffing form for the weekend and places them behind the Friday posting. The weekend charge nurse was responsible for changing the sheets over the weekend. The Unit Secretary further stated she was unsure why she did not post the staffing for 8/21/23.	F 732	It is the policy of the facility to update the current date, census, and staffing information on the staffing sheet daily and post in the appropriate location. Upon review the facility was properly staffed. Education was provided to nurse #2 on 8/23/23 that one of the responsibilities of the charge nurse is to ensure the staffing form is updated daily by the unit secretary or scheduler and that they are to check for accuracy prior to the sheet being posted. No residents were affected by the sheet not being posted. Scheduler, Unit Secretary, Medical Records and charge nurse on duty that day were educated by the Director of Nursing on how to properly fill out the census staffing sheet. Quality monitoring to be done daily by Director of Nursing, charge nurse or designee to ensure form is filled out accurately and completely and this it is updated and posted daily.This will be reviewed monthly by the QAPI committee for 3 months and will review any further corrective action needed.	

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F 732	Continued From page 24 During an interview on 8/23/23 at 9:50 AM, Nurse #2 stated she was the charge nurse over the weekend. She added she was not aware that she was responsible for changing the staff posting over the weekend. She stated she has recently become a registered nurse and was new to management responsibility. During an interview on 8/23/23 at 5:30 PM, the Administrator stated the nurse staff posting should be posted daily. The charge nurse was responsible for ensuring that the daily nurse staffing sheet was accurately completed by the Unit secretary and was posted daily near the elevator, so that it was clearly visible for residents and visitors.	F 732		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		10/8/23

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F 761	Continued From page 25 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to remove an expired multi-dose vial of insulin and discard loose pills in the medication cart drawer for 2 of 3 medication administration carts (200 short hall and 200 long hall). Findings Included: 1. On 8/20/23 at 9:10 AM, an observation of the long hall medication administration cart on 200 hall with Nurse #2 revealed in the second draw of the medication cart there were noted one white loose capsule and two blue round shape loose pills. On 8/20/23 at 9:20 AM, during an interview, Nurse #2 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #2 did not clean the cart before her shift. On 8/24/21 at 11:10 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for checking all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected that no expired items or loose pills be left in the medication carts.	F 761	It is the policy of the facility to ensure cart checks are completed every shift by oncoming licensed nurse to ensure the carts have no expired meds or loose pills. There was an expired insulin found on 200 hall cart at the beginning of shift. The resident that the insulin belonged too was no longer a resident at the facility at the time of the finding. Nurse #3 did not administer insulin during that shift and the medication was discarded per facility policy. The loose pills were also discarded per facility protocol. The RN supervisor and Director of Nursing inspected carts immediatly for any other potential expired medications. Licensed nurses were also educated that cart checks must be done each shift to check for expiring/expired medications on 8/20/23 The nurses were in-serviced by Omnicell pharmacy on 9/5/23. She educated that residents with orders for insulin have the potential to be affected by not properly checking expiration dates. Licensed nurses were also educated on proper storage and labeling of medications by the nurse educator from pharmacy. Nurse educator from Omnicare also did a thorough med pass evaluation with the licensed nurses on 9/5/23. Licensed nurses have been	

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F 761	Continued From page 26 2. On 8/20/23 at 9:30 AM, an observation of the short hall medication administration cart on 200 hall with Nurse #3 revealed one, half-empty multi-dose vial of Novolog insulin, opened on 7/2/23. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening (7/30/23). On 8/20/23 at 9:35 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible to discard expired multi-dose vials. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift. On 8/24/21 at 11:10 AM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for checking all the medications in medication administration carts for expiration date and remove expired medications every shift. She expected that no expired items or loose pills be left in the medication carts.	F 761	educated on a daily cart check and will be required to do a thorough weekly inpection checklist that will be turned into the Unit Manager or Director of Nursing. Director of Nursing will present the audits to the QAPI committee monthly times 3 months and will review any further corrective action needed.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		10/8/23

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F 812	Continued From page 27 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 keep food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. This practice had the potential to affect food served to all residents. The findings included: During a kitchen tour on 8/20/23 at 9:50 AM, the following observations were made with the Dietary Manager: a. The 8- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were substantial amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills. b. The 4-compartment ovens had a heavy grease buildup, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where food was being cooked. There was a dried grease buildup observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the	F 812	It is the policy of the facility to store/prepare/ distribute and serve food in accordance with professional standards for food safety. Dietary Manager upon notification and observation of survey concern reviewed the cleaning processes for the kitchen 8/21/23. Manager reviewed the process with the kitchen immediately to ensure cleanliness of equipment. And had equipment cleaned. Kitchen Staff in-serviced on 9/14/23 cleaning schedule and process by Dietary Manager. Administrator and Dietary Manager reviewed the inspection reports for the Person County Department of Environmental Health that inspects food preparation areas. The Health Department report dated 5/22/23 gives the Hospital Kitchen a score of 99.5 and showing equipment ,food/non-food contact surfaces approved, cleanable, properly designed. and non food contact surfaces clean. In a Steritech report an outside consulting group that provides inspection to the Contracted Kitchen service group HHS dated 8/3/2023 there is score of 95. This report states that	

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F 812	Continued From page 28 oven. c. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. The fryer had heavy grease and food build-up inside and outside, and food products behind the fryer. An interview was conducted on 8/20/23 at 9:50 AM. The Dietary Manager (DM) presented a checklist of the kitchen cleaning schedule. She stated staff were required to wipe down ovens, stove, and fryer daily after each meal and deep cleaned weekly. The DM further stated she was responsible for ensuring the kitchen staff kept the equipment clean and orderly. She added the kitchen equipment should be wiped down daily and cleaned weekly in accordance with the kitchen cleaning checklist. The DM confirmed the identified kitchen equipment had not been cleaned. Follow-up observation on 8/22/23 at 11:33 AM, was made of the identified kitchen equipment. The equipment remained the same as the initial tour on 8/20/23. Some areas have been worked on but not yet complete. An interview was conducted on 8/22/23 at 11:34 AM, the Cook stated there was a cleaning checklist. All staff were required to clean equipment in accordance with the clean checklist daily. The identified equipment had not been consistently cleaned therefore, there would be a buildup of grease. All staff were responsible for wiping down equipment after each use. An interview was conducted at 11:40 AM on 8/22/23, The Chief Cook stated the kitchen staff were required to wipe down kitchen equipment	F 812	Food contact surfaces are properly cleaned and sanitized. The Steri-tech inspection are done quarterly and reports will be reviewed and monitored by Dietary Manager and RD upon receipt to ensure compliance with proper cleaning and any noted concern. Reports will be submitted to ECU QAPI meeting upon receipt and monitored by Administrator and Dietary Manager, Chef , RD for compliance. Cleaning Logs for equipment will be reviewed monitored RD, Dietary Manager, Adm weekly to ensure compliance for completion. Dietary Manager will monitor daily on kitchen rounds to ensure equipment is cleaned to standard and will take action to educate staff and correct poorly cleaned items. Dietary Manager researched glass safety and cleaning on ovens and equipment of 30 + years in age. It is not uncommon for discoloring of glass area on ovens. This does not deem them upsafe. Kitchen will request a service review of oven by 10/8/23. To be reviewed in QAPI meeting for 3x months with submission of logs for cleaning equipment .	

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F 812	Continued From page 29 after each meal and deep cleaned weekly in accordance with the kitchen cleaning checklist. The Chief Cook stated he was responsible for ensuring the kitchen staff kept the equipment clean and orderly and to ensure the tasks were completed. He presented the last completed individual area cleaning schedule dated 8/14/23, which did not include the ovens, fryers, and stoves.	F 812		
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,	F 867		10/8/23

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and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions 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

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high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The 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

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F 867	Continued From page 32 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following a recertification and complaint survey on 1/7/22 in order to achieve and sustain compliance. This was for a recited deficiency on a recertification survey on 8/23/23. The deficiency was in the area of medication storage and kitchen sanitary condition. The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: The tag was cross referenced to: F761: Based on observations and staff interviews, the facility failed to remove expired multi-dose vial of insulin, stored in 1 of 3 medication administration carts (200 hall); failed to discard several loose pills that were identified in the medication cart's draw for 1 of 3 medication administration carts (200 hall). During the previous recertification surveys on 1/7/22, the facility failed to lock an unattended medication administration cart for 2 of 3 carts reviewed for medication storage (Rehabilitation Hall cart and Long Hall cart) and failed to lock the	F 867	It is the policy of the Facility to identify and analyze areas for improvement and have a system for monitoring, data gathering and measure/tracking improvement in areas self identified. Facility Administrator upon hire (4/24/23) reviewed the prior survey and was working with the team on prior systems identified as deficient. Kitchen inspection reports have been reviewed by the Department of Health (5/22/23) and Steritech report on 8/3/23. Scores were 99.5 for Dept. Of Health and 95 for the Steritech reports. There were no noted cleaning of equipment issues. The facility has had interim Director of Nursing and Administrator until full-time employment of LNHA on 4/24/23 and DON on 7/24/23. QAPI systems were accessed prior to survey and it was identified that an active QAPI system was not functioning fully. Process was started in May 2023 for monthly QAPI meetings and process is being re-established with development of Facility Management Team and staff. Monthly updates on QAPI project is to be reported to Compliance Officer and COO for review/monitoring. Updates are posted on the QAPI board maintained in hallway. Information will be reviewed with staff in monthly staff meetings by Administrator	

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F 867	Continued From page 33 controlled substances storage drawer on 1 of 3 carts (Rehabilitation Hall cart). F812: Based on observations and staff interviews, the facility failed to keep food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. This practice had the potential to affect food served to all residents. During the previous recertification surveys on 1/7/22, the facility failed to ensure the following kitchen equipment was clean: the stove, the oven, two compartment hot box and two compartment cold box. The facility failed to clean the cooler and discard rotten vegetables, expired juice, and unlabeled produce from 1 cooler. The facility failed to remove dented cans from use. On 8/23/23 at 6:20 PM, the Administrator indicated that all the citations would be reviewed, and a plan of correction would be put in place. The Administrator continued that the Quality Assistance and Assurance (QAA) committee met monthly, identified areas of concern, conducted the root cause analysis, created the plan of correction, and discussed the outcome. The Interdisciplinary Team will continue monitoring until the deficient area concerns will be resolved.	F 867	and DON x 3 and when changes of QAPI projects are altered.	