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F 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted from 10/3/23 through 10/4/23. Event ID # 1JFZ211. Additional information was obtained off-site on 10/12/23. The credible allegation of immediate jeopardy removal was validated on 10/17/23. Therefore, the exit date was changed to 10/17/23. The following intakes were investigated NC00208043, NC00207137, NC00206946, NC00205458, NC00203296, NC0020257 and NC00201233. 2 of the 26 allegations resulted in deficiency. Intake NC00201233 resulted in Immediate Jeopardy. Immediate Jeopardy was identified at: CFR 483.21 at tag F 661 at a scope and severity J. Immediate Jeopardy began 04/09/23 and was removed 10/14/23. CMS requested tag F624 to be changed to F661 on 11/8/2023.	F 000		
F 661 SS=J	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		10/18/23

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

Electronically Signed | 10/30/2023

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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F 661	Continued From page 1 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, Medical Director, and Pharmacist interviews, the facility failed to ensure a safe and orderly discharge for 1 of 1 sampled resident when Resident #3 was discharged to the community with medications prescribed for another resident (Resident #8) instead of his own medication on 4/9/23. On 4/18/23 Resident #3's Primary Care Physician (PCP) discovered that Resident #3 had been taking multiple medications he was not prescribed and had not taken his own prescribed medications since his discharge from the facility on 4/9/23. Discharging a resident with medications not prescribed for him and without his own prescribed medications had a high likelihood of resulting in serious harm. In addition, the facility failed to have the discharge summary signed by the resident and/or responsible party.	F 661	F661 On 4/9/2023 Universal Healthcare of Concord discharged Resident # 3 home with wrong medication. Nurse #1 failed to review medication list and compare it with the actual medication with family and have it signed by family or resident #3. Resident #3 was discharged home with family on 4/9/23. The discharge summary dated 4/9/23 indicated Resident #3 was prescribed a medication for gout, hypertension, and multivitamins. The discharge summary was not signed by the resident, family member or the nurse that discharged the resident. When Resident #3 was seen by his Primary Care Physician on 4/18/23 it was discovered Resident #3 had been taking medications prescribed to Resident #8 since his	

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F 661	Continued From page 2 Immediate Jeopardy began on 4/9/23 when the facility discharged Resident #3 with another resident's medications in place of his own. Immediate Jeopardy was removed on 10/14/23 when the facility implemented a credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential of minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put into place are effective. Findings included: Resident #3 was admitted to the facility on 3/23/23. His cumulative diagnosis included cognitive communication deficit, hypertension (high blood pressure), thrombocytopenia (low platelet levels), and gout (a form of inflammatory arthritis characterized by sudden, severe attacks of pain, swelling, redness, and tenderness in one or more joints). Review of the admission Minimum Data Set (MDS) dated 3/31/23 showed Resident #3 was moderately cognitively impaired. Review of Resident #3's electronic records showed the following allergies listed: lisinopril (used to treat blood high blood pressure) and hydrochlorothiazide (used to treat high blood pressure). The type of allergic reactions to the medications were not listed. Review of Resident #3's electronic medical records showed a physician progress note dated	F 661	discharge from the facility on 4/9/23. Nurse Practitioner called resident #1 medications in to the pharmacy of their choice on day of discharge 4/9/2023. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/3/2023 upon learning of the alleged incident the Director of Nursing began re-educating all licensed nurses on discharge process to include, all discharges home medications are to be signed and reviewed by 2 nurses prior to discharging residents with medications. All residents discharged home with medications are at risk of being affected by this alleged deficient practice. The complete audit of all discharges home to ensure that all medications lists had been reviewed and signed by family and discharging nurse as of 4/9/2023 has been completed by Social Worker and Director of Nursing as of 10/13/2023. Any discrepancies have been addressed. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 10/13/2023 Director of Nursing re-educated all nurses on facility policy for discharge and sending medications home as of 10/13/2023. All nurses were educated to review medications with family prior to discharge and have family sign discharge medication list as of 10/13/2023. The medication list and discharge medication packets will be	

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F 661	Continued From page 3 4/7/23 that read in part "Made aware resident is discharging on Sunday and needs discharge summary completed please. He will need. . . home health services for physical therapy, occupational therapy, and speech therapy. . . He is needing medications sent to the pharmacy of his choice for thirty days. Follow up with outside primary care provider." Review of a social worker note dated 4/7/23 read in part "called (family member) to give confirmation of discharge plans - (family member) was not available but I left a detailed voice mail with all information she will need. I spoke with resident as well in regard to discharge plans. . . Discharge packet will be left with nurse." Review of Resident #3's Discharge Summary dated 4/9/23 showed the following medication orders: - febuxostat 40 milligrams (mg) tablet give one tablet by mouth daily for gout. - metoprolol succinate give one tablet by mouth daily for hypertension - multivitamin tablet give one tablet by mouth daily for supplement. The discharge summary was not signed by Resident #3, Resident #3's responsible party, or the nurse (Nurse #2) who discharged Resident #3. Review of a nursing progress note completed by Nurse #2 dated 4/9/23 at 4:55 P.M. read in part "Resident discharge to home with family. All belongings and medications sent with resident and family. Uneventful discharge. Medications reviewed with family and resident prior to departure and further discharge orders also	F 661	reconciled by two nurses and family prior to discharge as of 10/13/2023. All new hires will be educated on discharge medication process prior to starting their first shift by the Director of Nursing as of 10/13/2023. The facility does not use agency staffing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Director of Nursing re-educated all nurses on facility policy for discharge and sending medications home as of 10/14/2023. All nurses were educated to review medications with family prior to discharge and have family sign discharge medication list. DON/Designee will monitor all discharge home medication daily for 4 weeks, then 3 times weekly for 4 weeks and weekly thereafter for 4 weeks. Director of Nursing/ Nurse Manager will report all findings to the Quality Assurance Performance Improvement (QAPI) team for any needed changes or improvements. QAPI team will review findings for six months to ensure continued compliance. Include dates when corrective action will be: 10/14/2023 Compliance date: 10/18/2023	

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reviewed. All expressed understanding at this time."

Review of Resident #3's primary care follow-up visit notes dated 4/18/23 read in part "Patient states was discharged on 4/9/23. Review of medications patient was discharged on reveals incorrect patient medications. Patient has subsequently been taking clopidogrel [antiplatelet medication that works by preventing clotting factors in the blood from sticking together], carbidopa & levodopa [combination medication used to treat Parkinson's disease symptoms. Levodopa changes into a chemical in the brain to help control muscle movements. Carbidopa prevents the breakdown of levodopa in the bloodstream so more levodopa enters the brain], pantoprazole [decreases the amount of acid in your stomach and used to treat acid reflux and heal stomach/throat ulcers], and methimazole [treats overactive thyroid by stopping the thyroid from making too much thyroid hormone], for the last 2 weeks, none of which he has need for. Uncertain what meds he was actually taking in the Skilled Nursing Facility. Patient's family member reports they did not think anything of the incorrect name because it came with the paperwork with his name on it. Reports the nurse read through each medication and how to take it with the patient and then provided it to them. Patient has taken 9-10 days of these medications." Resident's blood pressure on 4/18/23 at 12:45 P.M. was 134/78 millimeters of mercury (mmHg. (normal systolic blood pressure reading is less than 120 mmHg/ less than 80mmHg).

An interview was attempted with Resident #3's Primary Care Physician and was unsuccessful.

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Review of the prescribing guides listed the following side effects are listed as possible:
- clopidogrel: may cause bleeding which can be serious and lead to death, may cause clots to form in blood vessels in as little as two weeks, feeling tired/weak, seizures, fast heart rate or feeling short of breath, headaches, confusion, vision changes, stomach pain, nausea, vomiting, or diarrhea.
- carbidopa & levodopa: fatigue, abdominal pain, heart attack, heart palpitations, high or low blood pression, blurred vision, decreased mental acuity, memory impairment,
- pantoprazole: headache, diarrhea, nausea, stomach pain, vomiting, gas, dizziness, and joint pain
- methimazole: joint/muscle pain, decreased white blood cells, decreased platelets, dizziness, swelling, upset stomach

A telephone interview was conducted on 10/3/23 at 10:39 A.M. with Resident #3's family member. Resident #3's family member stated Resident #3 administered medications to himself. Resident #3's family member stated Resident #3 went to his primary care physician (PCP) on 4/18/23 for a follow-up appointment after his discharge from the facility. Resident #3 took the medication the facility had given him to his PCP appointment. During this appointment, the PCP identified Resident #3 had been provided another resident's medications and Resident #3 had taken the wrong medications since his discharge from the facility. Resident #3's family member confirmed Resident #3 was sent home with medications that did not have a label with Resident #3's name on the package and instead had the name of another resident. The family member did not

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disclose how many medications packages prescribed to another resident were sent home with Resident #3. The family member did state Resident #3 was not sent home with any of the medications prescribed to him when he was discharged from the facility. During the interview, Resident #3's family member provided Resident #8's name and date of birth from the bubble packages sent home with Resident #3. Resident #3's family member explained Resident #3 and the family had recognized there were more medications, but they thought the facility had changed Resident #3's medication while he was a resident at the facility. The family member explained Resident #3 had taken the medications as the nurse had instructed at discharge. Resident #3's family member stated the PCP had concerns about the effects of the blood thinners on Resident #3 due to him having a diagnosis of anemia and labs were drawn at his follow up visit with the PCP to check his blood levels. Resident #3's family member did not have the results from the lab work. Resident #3's family member stated Resident #3 appeared to have increase in weakness, confusion, and gout symptoms after his discharge from the facility. Resident #3's family member did not explain if the symptoms had improved.

An interview was conducted on 10/4/23 at 10:21 A.M. with the Social Worker (SW). The SW explained due to the length of time since Resident #3 was discharged, she was unable to recall the specifics of his discharge. During the interview, the SW stated when a resident was scheduled to be discharged on a weekend, she called the family member the Friday prior to discharge and discussed the discharge plan with them. The plan included medical equipment

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ordered for the resident, any referrals made, and any supportive services in place to assist the resident with the transition back into the community. The SW indicated she placed a copy of the resident's demographic face sheet and the last physician progress note into an envelope and placed the envelope at the nursing station corresponding to the hallway the resident was residing on. The SW further stated nursing staff were responsible for printing a discharge summary, explaining medications, and gathering the medications to send home with the resident at the time of discharge.

Review of Resident #8's medical record showed the following physician medication orders active on 4/9/23.

- Aspirin (used as a blood thinner to reduce the risk of strokes) 81 one tablet daily
- Carbidopa-Levodopa (used to treat symptoms of Parkinson's disease)
- 61.25- 245 mg one table by mouth daily
- Citalopram (used to treat depression) 40mg tablet give one tablet by mouth daily
- Clopidogrel (blood thinner used to prevent strokes and heart attacks) 75mg tablet one tablet by mouth daily
- Vitamin B12 (assists to form red blood cells) 500 micrograms (mcg) tablet give one tablet by mouth daily
- Pantoprazole (used to reduce the amount of acid the stomach makes) 40mg tablet by mouth daily
- Methimazole (used to treat an overactive thyroid) 5mg give one tablet by mouth every other day
- Atorvastatin (used to lower bad cholesterol and triglycerides in the blood) 40mg tablet give two tablets by mouth at bedtime.

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Review of Resident #8's Medication Administration Record for 4/9/23 and 4/10/23, showed Resident #8 received his scheduled medications.

A telephone interview was conducted on 10/3/23 at 6:05 P.M. with Nurse #2 who discharged Resident #3 on 4/9/23. Nurse #2 stated when a resident was discharged from the facility, the nurse who completed the discharge was responsible for reviewing all the discharge paperwork included in the discharge packages. These discharge instructions included how to take each medication and to review the medication packages sent home with the resident and/or the resident's family member at the time of discharge. The nurse indicated at discharge the resident and/or the resident's family member should have restated the discharge instructions to confirm they understood the instructions and signed a copy of the discharge summary; the signed copied stayed at the facility and a second copy was provided to the resident and/or the resident's family at the time of discharge. Nurse #2 explained she was asked by a coworker to complete Resident #3's discharge on 4/9/23 and the coworker told her (Nurse #2) Resident #3's medications had been gathered into the bag for his discharge. Nurse #2 was unable to recall who asked her to discharge Resident #3 or who gathered the medication packages into a bag for discharge. During the interview, Nurse #2 stated Resident #3 was not alert and oriented. Nurse #2 went over the discharge instructions with Resident #3's family member as Resident #3's family member was packing up Resident #3's

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belongings. Nurse #2 explained she did not review any of the medications packages when she gathered the documentations and medications for Resident #3's discharge or when she provided the discharge package and medications to Resident #3's family. The nurse stated she should have checked to see if Resident #3's name was on the medication bubble packages prior to giving the medication to his family. Nurse #2 did not provide a reason for not checking Resident #3's name on the bubble sheets of medication given to Resident #3's family at discharge.

A telephone interview was conducted on 10/4/23 at 2:53 P.M. with the Pharmacist. During the interview, the Pharmacist reviewed Resident #8's medical chart and started the pharmacy had filled and sent Resident #8's prescriptions on 4/6/23 and on 4/10/23. The Pharmacist reviewed the notes in Resident #8's chart and stated there was not a note written about why the facility had requested all of Resident #8's medications to be refilled four days after the pharmacy had sent the facility his prescriptions. During the interview, the Pharmacist was unaware Resident #8's medication had been sent home with another resident at discharge. The Pharmacist explained the facility had a backup pharmacy on-site with most of the medications Resident #8 was prescribed available for administration. During the interview the Pharmacist explained medications were prescribed by a provider for very specific medical conditions and an individual should never take another individual's medications without first consulting their medical doctor. The Pharmacist explained medication reactions varied from person to person and the dosing of medications

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could affect these reactions. The Pharmacist did not provide possible outcomes for Resident #3 due to taking medications prescribed to Resident #8 after he was discharged from the facility.

An interview was conducted on 10/4/23 at 12:49 A.M. with the Medical Director. The Medical Director reviewed the list of medications for both Resident #3 and Resident #8. After reviewing the list of medications, the Medical Director explained there should be no significant medical effects on Resident #3 after taking Resident #8's medications for nine days or for not taking his prescribed medications for the nine days. During the interview, the Medical Director stated Resident #3 should have been sent home with the medications prescribed to him and not another resident's medications. The Medical Director was unable to state how this error occurred, but stated he felt like it was a mistake made by the nursing staff during Resident #3's discharge.

An interview was conducted on 10/4/23 at 1:23 P.M. with the Director of Nursing (DON). During the interview, the DON stated a resident being sent home with another resident's medications should not have occurred. The DON explained the nurse who discharged Resident #3 from the facility had the responsibility to review both the list of medications and the bubble packages of medication with Resident #3 and/or his responsible party prior to him being discharged from the facility. The DON stated she had no explanation to how Resident #3 was sent home with another resident's medication.

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An interview was conducted on 10/4/23 at 2:50 P.M. with the Administrator. During the interview the Administrator stated bubble packages of medications should never leave the facility with a resident who was not prescribed the medication. The Administrator stated it's not the facility's normal practice to send medication home with residents at discharge, unless the medications were sent home due to insurance requirements, and he is unsure how this mix-up occurred.

The Administrator was notified of the Immediate Jeopardy on 10/12/23 at 2:51 P.M. On 10/13/23 the facility provided the following credible allegation of Immediate Jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome because of the non- compliance:

On 4/9/2023 Universal Healthcare of Concord discharged Resident #3 home with wrong medication. Nurse #1 failed to review medication list and compare it with the actual medication with family and have it signed by family or Resident #3. Resident #3 was discharged home with family on 4/9/23. The discharge summary dated 4/9/23 indicated Resident #3 was prescribed a medication for gout, hypertension, and a multivitamin. The discharge summary was not signed by the resident, family member or the nurse that discharged the resident. When Resident #3 was seen by his Primary Care Physician on 4/18/23 it was discovered Resident #3 had been taking medications prescribed to Resident #8 since his discharge from the facility on 4/9/23.

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F 661	Continued From page 12 On 10/3/2023 upon learning of the alleged incident the Director of Nursing began re-educating all licensed nurses on discharge process to include, all discharges home medications are to be signed and reviewed by 2 nurses prior to discharging residents with medications. All residents discharged home with medications are at risk of being affected by this alleged deficient practice. Specify action the facility will take to alter the process or system failure to prevent a serious outcome from occurring or recurring and when the action will be completed: The complete audit of all discharges home to ensure that all medications lists had been reviewed and signed by family and discharging nurse as of 4/9/2023 has been completed by Social Worker and Director of Nursing as of 10/13/2023. As of 10/13/2023 Director of Nursing re-educated all nurses on facility policy for discharge and sending medications home as of 10/13/2023. All nurses were educated to review medications with family prior to discharge and have family sign discharge medication list as of 10/13/2023. The medication list and discharge medication packets will be reconciled by two nurses and family prior to discharge as of 10/13/2023. All new hires will be educated on discharge medication process prior to starting their first shift by the Director of Nursing as of 10/13/2023. The facility does not use agency staffing.	F 661		

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F 661	Continued From page 13 Allegation of Immediate Jeopardy removal date: 10/14/23 The credible allegation was verified on 10/17/23 through interviews conducted with nursing staff that showed they had received training about discharge procedure, all discharged medications are to be signed and reviewed by two nurses prior to discharging residents' home with medications. A review was completed of educational information provided to staff during the in-service and a review of in-service staff sign-in logs. The in-service logs were viewed, staff names were randomly selected and verified to have received training. A newly hired nurse was verified to have received discharge training by the Director of Nursing. A review of discharges from 4/9/23 through 10/13/23 identified no concerns. The facility had one discharge on 10/14/23. The responsible party refused to go to the facility to sign discharge paperwork. Medications were reviewed with the responsible party via telephone with two nurses. The facility's immediate jeopardy removal date of 10/14/23 was validated.	F 661		
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		10/18/23

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F 812	Continued From page 14 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 remove expired food from 1 of 1 dry storage room and failed to date and label opened food in 1 of 1 walk in cooler. The findings included: a. On 10/3/2023 at 9:42 a.m. observations were made of the facility's dry storage area with Dietary Staff #1. Contents stored in the dry storage area were noted to have 14 containers of ready care thickened orange juice with an expiration date of 8/11/2023 and 2 with an expiration date of 7/27/2023. A box of opened coconut flakes was dated as opened on 10/5/2022. 7 bags of jet puffed marshmallows were on a shelf with an expiration date of 3/3/2023. During the observation of the dry storage on 10/3/2023 at 9:42 a.m. an interview was conducted with Dietary Staff #1, and she revealed all expired food was to be discarded and not stored in the kitchen area. She added all opened food, in the dry storage area, should be discarded and thrown away within a few months, but she was unsure of the exact date it should be thrown out.	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/3/2023 all expired and undated food was removed from the dry storage room and refrigerators by the Dietary manager. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: As of 10/14/2023 Dietary manager completed audit all food storage areas to include dry storage, coolers, and freezers to ensure there was no outdated or unlabeled food. Any undated or expired food was removed during the audit. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: As of 10/14/2023 Dietary Manager re-educated all dietary staff on facility policy for food procurement to include labeling and dating food when open and discarding all foods on expiration date.	

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F 812	Continued From page 15 b. On 10/3/2023 at 9:58 a.m. observations were made of the facility's walk-in cooler with Dietary Staff #1. Upon entrance there was observed a package of chopped ham, opened, and wrapped in plastic wrap with no label or date. There was a metal container with lettuce, sliced tomato, and sliced onion, covered with plastic wrap on a cart. There were no labels or dates on the container. During the observation of the walk-in cooler on 10/3/2023 at 9:58 a.m. an interview was conducted with Dietary Staff #1, and she revealed all opened items should have a date when opened and should be discarded within 3 days of being opened. An interview was conducted with the Certified Dietary manager (CDM) on 10/4/2023 at 2:18 p.m. and she revealed any expired items should have been tossed out immediately. Any opened items in the dry food storage should not have remained in the dry food storage but should have been discarded within 7 days. She added, she began her role 8/28/2023 and then had been out of work sick the previous 10 days. She had been working to retrain staff. She added she was going through the kitchen in sections to assess the areas that required clean-up and reorganizing. She revealed in the refrigerator/walk in cooler any opened food placed inside should have been covered and labeled with a date opened and the date to discard. The Administrator was present during the interview with the CDM on 10/4/2023 at 2:18 p.m., and he stated he had nothing to add to her interview and that it was his expectation that there be no expired food stored in the facility.	F 812	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Administrator/Designee will monitor food storage areas daily for 4 weeks, then 3 times per week for 4 weeks and weekly for 4 weeks to ensure all food items are stored and dated properly. Dietary Manager will report all findings to the Quality Assurance Performance Improvement (QAPI) team for any needed changes or improvements. QAPI team will review findings for six months to ensure continued compliance. Include dates when corrective action will be: 10/14/2023.	

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F 867	Continued From page 16	F 867		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §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	F 867		10/18/23

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F 867	Continued From page 17	F 867		

facility will use the data to develop activities to prevent adverse events.

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

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health 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

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F 867	Continued From page 18 implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews and observations, the facility's Quality Assurance and Performance committee (QAPI) failed to maintain	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 867	Continued From page 19 implemented procedures and monitor the interventions the committee put into place for 1 re-cited deficiency F812. F812 was originally cited during the recertification and complaint investigation survey dated 07/15/21, F812 was re-cited during a revisit and complaint investigation dated 09/20/21, F812 was re-cited during a recertification and complaint investigation dated 12/08/22, and F812 was re-cited during a complaint investigation dated 10/17/23. The continued failure of the facility during four federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. The findings included: This tag is cross-referenced to: 1.F812: Based on observations and staff interviews the facility failed to remove expired food from 1 of 1 dry storage room and failed to date and label opened food in 1 of 1 walk in cooler. During the recertification and complaint investigation of 07/15/21, the facility failed to clean 40 of 40 plastic ceiling light covers, 1 of 1 microwave oven, 8 of 8 oven knobs and 1 of 1 fryer, and failed to label items in the dry storage room, walk-in refrigerator and the walk-in freezer, and stored 5 of 5 frozen food boxes on the freezer floor. During the revisit and complaint investigation of 09/20/21, the facility failed to clean food service equipment and failed to date and/or label, or discard, items in the walk-in cooler. The facility	F 867	practice:¿ ¿ Administrator reviewed all prior citations of F812 for need to continue monitoring as of 10/18/23 for the prior one year.. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:¿ No residents were affected but all residents have the potential to be affected. Administrator has reviewed all repeated citations for continued compliance as of 10/18/23. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Regional Director of Operations has re-educated Administrator on Quality Assurance on prior cited tags continuing the Quality Assurance Performance Improvement process until citations are completely resolved on 10/18/23. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: On 10/18/2023 the Regional Director of Operations (RDO) educated the Administrator and Director of Nursing on the QAPI process regarding proper monitoring and continued monitoring of areas of non-compliance to ensure continued compliance. RDO will review	

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F 867	Continued From page 20 failed to maintain clean contact surface on five of six knobs on the six burner/flat top/two over stove and failed to date and/or label items in one of one observed cooler unit. During the recertification and complaint investigation of 12/08/22, the facility failed to 1) wash dishes in the dish machine in water that reached at least 155 degrees Fahrenheit (F), per manufacturer recommendations, 2) store frozen foods at least 0 degrees F, and 3) store canned goods and snacks off the floor. An interview was conducted with the Administrator on 10/04/23 at 4:50 PM. The Administrator explained that during the monthly QAPI meetings, the QAPI committee did not report any dietary concerns and there was no Performance Improvement Plan implemented since he became the Administrator in January of 2023. The Administrator revealed he believed that all previous survey citations had been resolved and the facility was back in compliance based on previous audits.	F 867	QAPI notes monthly to ensure continued compliance of areas of non-compliance. As of 10/18/2023 Administrator will have QAPI meeting bi-weekly for 3 months to ensure all areas of non-compliance are being monitored and corrective actions are being completed as assigned. The administrator will report their findings to the Quality Assurance Performance Improvement (QAPI) committee for any needed improvement. QAPI committee will review monthly and make any necessary recommendations immediately for 6 months. Compliance date: 10/18/2023	