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	345551	A. BUILDING ______ B. WING ______	C 04/29/2021

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PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification and complaint survey was conducted on 04/26/21 through 04/29/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #SR1V11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the Preadmission Screening and Resident Review (PASRR) Level II status (Resident #61, Resident #52, Resident #2, Resident# 31, Resident#29) for 5 of 18 residents whose MDS assessments were reviewed. Findings include: 1. Resident #61 was readmitted to the facility on 7/24/20 with a cumulative diagnosis which included schizophrenia and major depression. Resident #61's admission forms indicated identification as a PASRR Level II (a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines). A review of Resident #61's most recent comprehensive MDS assessment dated 1/28/21 did not indicate identification as a PASRR Level II.	F 641	Description of the Deficient Practice Facility failed to accurately code the Minimum Data Set (MDS) assessment to indicate the Preadmission Screening and Resident Review (PASRR) Level II status (Resident #61, Resident #52, Resident #2, Resident #31, Resident #29) for 5 of 18 residents whose MDS assessments were reviewed. Corrective Action for those Residents found to have been affected Resident #61 admitted to the facility on 7/24/2020. Resident remains at baseline. Resident #52 admitted to the facility on 4/12/2019. Resident remains at baseline. Resident #2 admitted to the facility on 7/21/2011. Resident remains at baseline. Resident #31 admitted to the facility on 9/6/2017. Resident remains at baseline. Resident #29 admitted to the facility on 2/22/2021. Resident remains at baseline.	6/7/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2021

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 641

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An interview was conducted on 4/27/21 at 1:48 PM with the facility's Social worker (SW). SW reported Resident #61 was a PASRR Level II resident and was coded incorrectly on the MDS assessment.

An interview was conducted on 4/27/21 at 12:46 PM with the facility's MDS coordinator. The MDS coordinator stated Resident #61 had a PASRR Level II identification. MDS coordinator also stated Resident #61's most recent comprehensive assessment had not been coded correctly.

An interview was conducted on 4/28/20 at 3:00 PM, with the facility's Director of Nursing (DON). During the interview, the DON stated she expected the MDS Coordinator and Social Worker to work together to make sure the PASSR coding was correct on annual and significant change MDS assessments.

An interview was conducted on 4/29/21 at 1:09PM with the facility's administrator. During the interview, the administrator stated he expected the PASSR on the MDS to be coded correctly and reviewed as needed.

2. Resident #52 was readmitted to the facility on 4/12/19 with a cumulative diagnosis which included bipolar and major depression. Resident #52's admission forms indicated identification as a PASRR Level II (a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines).

A review of Resident #52's most recent comprehensive MDS assessment dated 2/20/21

F 641

Each resident□s PASRR Level II status has been reviewed and MDS assessments have been modified and submitted ensuring that the PASRR Level II status has been coded accurately to reflect a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines.

Corrective Action to identify potential affected residents

Each resident□s PASRR Level II status has been reviewed and MDS assessments have been modified and submitted ensuring that the PASRR Level II status has been coded accurately to reflect a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines.

Ongoing Corrective Action

The facility has reviewed its□ MDS Assessment Accuracy policy. Case Mix Director has been re-educated to the facility MDS Assessment Accuracy Policy.

Monitoring Plan QA

The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows:
1) All residents will be reviewed and discussed by the IDT at the time of

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did not indicate identification as a PASRR Level II.

An interview was conducted on 4/27/21 at 1:48 PM with the facility's Social worker (SW). SW reported Resident #61 was a PASRR Level II resident and was coded incorrectly on the MDS assessment.

An interview was conducted on 4/27/21 at 12:46 PM with the facility's MDS coordinator. The MDS coordinator stated Resident #61 had a PASRR Level II identification. MDS coordinator also stated Resident #61's most recent comprehensive assessment had not been coded correctly.

An interview was conducted on 4/28/20 at 3:00 PM, with the facility's Director of Nursing (DON). During the interview, the DON stated she expected the MDS Coordinator and Social Worker to work together to make sure the PASSR coding was correct on annual and significant change MDS assessments.

An interview was conducted on 4/29/21 at 1:09PM with the facility's administrator. During the interview, the administrator stated he expected the PASSR on the MDS to be coded correctly and reviewed as needed.
4. Resident #31 was admitted to the facility on 9/6/17 with a cumulative diagnosis which included schizophrenia and major depression. PASSR determination date 2/2/2017.

Review of a Preadmission Screening and Resident Review (PASRR) Level II list provided by the facility revealed Resident #31 had serious mental illness and a PASRR number which ended

F 641

Admission Assessment and Annual Comprehensive Assessment during morning stand-up meetings ensuring MDS assessment accuracy.
2) Facility CMD, LNHA, or designee will audit all residents who have received an Admission Assessment or an Annual Comprehensive Assessment weekly x4 and then monthly x3; confirming all MDS assessments are coded accurately to reflect a resident identified as having a serious mental illness or intellectual debility.
Results will be presented by the CMD or LNHA to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring.

Date for Correction June 7, 2021

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with the letter "B" (indicative of a PASRR Level II determination). Determination of a PASRR Level II resident is made by an in-depth evaluation. Results of the evaluation would be used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care.

Resident #31's annual Minimum Data Set (MDS) assessment dated 728/20 was reviewed. Section A1500 of the MDS indicated the resident was not considered by the State Level II PASRR process to have a serious mental illness and/or intellectual disability.

An interview was conducted on 4/27/21 at 1:48 PM with the facility's Social worker (SW). SW reported Resident #31 was a PASRR Level II resident. SW stated it was the responsibility of MDS coordinator to code PASSR on MDS assessment. The resident ' s PASSR information was indicated on the resident ' s face sheet and must be reviewed to prior to completing section A1500 on the MDS.

An interview was conducted on 4/27/21 at 12:46 PM with the facility ' s MDS coordinator. The MDS coordinator reviewed the resident's 1/28/21 annual MDS assessment and reported Section A1500 was incorrectly coded. She stated this section should have indicated Resident #31was a PASRR Level II resident.
3. Resident #2 had been admitted on 7-21-11 with diagnoses of schizoaffective disorder. Resident 2 's admission forms indicated identification as a Level II PASRR (a resident identified as having a serious mental illness or intellectual debility as defined by state and federal

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guidelines).

A review of Resident #2's most recent comprehensive MDS assessment dated 11-20-20 section A 1500 did not indicate identification as a Level II PASRR.

During an interview on 04/27/21 at 12:30PM the MDS nurse stated PASRR II Resident #2 should be coded ,"Yes" on the annual assessment.

During an interview on 04/29/21 02:05 PM the SW stated, Resident#2 was identified as Level II PASRR.

5. Resident #29 was admitted on 2/22/21 with a diagnosis of schizophrenia.

A review of the Resident #29's most recent comprehensive Minimal Data Set (MDS) dated 2/22/21, did not indicate Resident #29 had a PASRR Level II determination.

On 4/27/21 at 1:58 PM an interview with the facility Social Worker (SW) was conducted she stated Resident #29 had been identified as PASRR Level II. When showed the MDS, SW agreed the MDS should have included Resident #29 had PASRR Level II and did not. SW stated the MDS coordinator was responsible for coding the MDS.

On 4/27/21 at 12:21 PM an interview with the facility MDS Coordinator stated it was her responsibility to code PASRR Level II and she indicated Resident #29's MDS was incorrectly

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F 641	Continued From page 5 coded for PASRR Level II. An interview was conducted on 4/29/21 at 1:09PM with the facility's administrator. During the interview, the administrator stated he expected the PASRR Level II to be coded correctly on the MDS and reviewed as needed.	F 641		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed provide splinting application per therapy recommendations for 1 of 2 sample residents (Resident #31) reviewed for range of motion/contractures. The findings included:	F 688	Description of the Deficient Practice Based on observation, staff interviews and record review, the facility failed to provide splinting application per therapy recommendations for 1 of 2 sample residents (resident #31) reviewed for range of motion/contractures.	6/7/21

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Resident #31 was admitted to the facility on 9/6/17 with diagnoses included seizure disorder, cerebral infarction, hemiplegia/ hemiparesis and left side contractures of elbow, hand and knee. The quarterly Minimum Data Set (MDS) dated 2/9/21, revealed Resident #31 was cognitively impaired and required total assistance with all activities of daily living. The MDS revealed Resident #31 had functional impairment to the upper and lower extremities on one side.

The care plan dated 1/20/21, identified Resident #31 had ADL functional / rehabilitation potential problem as Resident #31 required left upper extremity (LUE) passive range of motion (PROM) to all joints all planes for contracture management. Resident #31 also to wear L elbow extension and resting hand splints 6 hours per day for contracture management. Resident #31 required passive range of motion and positioning to left lower extremity 7 days per week. Resident would (improve,) range of motion of Left hip and knee to improve bed and chair position with leg out of position (full external rotation and flexion). Resident #31 would be placed in restorative nursing program: gently range left hip to bring leg toward neutral rotation position when resident was lying on back, Place pillow under left knee to support knee, place blue wedge along outside of left hip and upper leg to support , 2 hours per shift.

Review of physician orders dated 9/20/19, documented 07:00 AM 03:00 PM, apply left elbow extension splint and left functional hand splint 6-8 hours daily as tolerated. Evenings 03:00 PM 11:00 PM, apply left elbow extension splint and left functional hand splint 6-8 hours daily as

F 688

Corrective Action for those Residents found to have been affected

Resident #31 admitted to the facility on 9/6/2017. Resident #31 has splint applied per physician□s order by nursing assistant with application documented by Charge Nurse starting April 19, 2021.
Corrective Action to identify potential affected residents
Therapy Outcomes Coordinator conducted audit starting April 15, 2021 of residents discharged from therapy services within past 30 days to determine if a splint therapy program was recommended. Residents needing a splint received orders from the Therapist recommending the device for placement. Charge Nurses of the residents were educated by the Therapy Outcomes Coordinator regarding splint order and documentation of splint placement.

Ongoing Corrective Action

Therapy Outcomes Coordinator educated nursing and administrative employees (Social Worker, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Human Resources, and Financial Coordinator) regarding application and documentation of splints to residents with orders for them to be in place starting April 19, 2021. Education included nursing assistants applying and removing the splints with Charge Nurses documenting the application. Facility IDT will conduct Compliance Rounds on

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F 688	Continued From page 7 tolerated. Review of in-service dated 2/15/2021: Left upper extremity (LUE) contracture management. Resident is to receive passive range of motion (PROM) to LUE shoulder, elbow and wrist to decrease stiffness & prevent further contracture. Resident was to wear L elbow brace 6-8 hours daily to decrease flexor tone & prevent further contracture. Resident was to wear left resting hand splint 4-8 hours daily to decrease further risk of contracture (5 staff were trained). Review of the occupational therapy discharge summary dated 2/16/21: splinting time resident would tolerate left elbow extension for 3 hours, with application of elbow splint in order to prevent contracture. goal met on 2/16/21 resident tolerated left elbow extension and resting hand splint for 6-8 hours. Staff training regarding resident splinting/rom program. Review of Medication Administration on 4/26/21-4/29/21 documented splints were applied on 1st shift and 2nd shift when observations revealed Resident #31 ' s splints had not been applied during scheduled shifts and all splints were not available for application. Observation on 04/26/21 at 02:21 PM, Resident #31 in bed without left elbow/hand splints. Observation on 4/26/21 at 3:10 PM, Resident #31 in bed without left/elbow hand, splints and bunny boots on top of the closet. Observation on 4/27/21 at 8:45 AM, Resident #31 in bed without left elbow/hand splints and bunny boots remain on top of the closet.	F 688	residents with orders for splints to ensure they are in place. Monitoring Plan QA The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: Administrative Nurses (Director of Health Services, Infection Preventionist, RN MDS Coordinators, RN Skin Integrity Nurse, Assistant Director of Health Services, and RN Clinical Competency Nurse) will audit residents with orders for splints to ensure placement and subsequent documentation weekly x3 then monthly for three months. Results will be presented by the Director of Health Services and/or the Administrator to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring Date for Correction June 7, 2021	

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Observation on 4/27/21 at 10:20 AM, Resident #31 in bed without left elbow/hand splints and bunny boots remain on top of the closet.

Observation on 4/27/21 at 1:51 PM, Resident #31 was in bed without left elbow/hand or knee splints on. Resident#31 was uncertain of the frequency of when the splints should be applied. Resident #31 stated staff did not put the splints on him on a regular basis, the splints were usually put in a closet where they stayed most of the time. Additional, observations included bunny boots were on the very top and the elbow splint was tucked under clothing in the open closet.

Observation on 4/28/21 at 9:40 AM, Resident #31 was in bed watching television, bunny boots on top of the closet. Resident #31 did not have any splints on, elbow, hand or knew. Resident#31 stated he had not worn the elbow/hand splint in a while and thought they were in the closet somewhere under stuff.

Interview on 4/28/21 at 10:10 AM, the Nurse Aide #3(NA) stated Resident #31 was being seen by therapy 3x weeks and they were applying the splints to elbow and hand. NA#3 stated he was unaware of the actual schedule of when the splints should be applied and removed. NA#3 also stated range of motion (ROM) should be done with resident during activities of daily living (ADL) care and when the resident was up in the wheelchair. NA#3 stated he did not know exactly where the splints were located. NA#3 did a full room search with surveyor present and found only the elbow splint in the closet under a pile of clothing, he stated there was no hand splint found in the search and he had to check with nursing

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F 688	Continued From page 9 and therapy. NA#3 stated he did not know where to document when the splints were applied and at what time. Interview on 4/28/21 at 10:20 AM, Nurse #2 stated per the orders the left elbow/hand splint should be applied at 7:30 AM-3:00 PM, and 3-11PM, additional order splints to be applied 6- 8 hours. The Nurse also stated nursing should be documenting when splints were applied and remove, Nurse #2 observed Resident #31 in bed and confirmed the resident did not have splint in place. Nurse #2 was unaware of where the splints were located. Interview on 4/28/21 at 10:30 AM, Nurse #5 worked 2nd shift on 4/26/21 and 1st shift 4/27/21 with Resident #31. Nurse #5 reviewed the orders which confirmed 7:30 AM-3:00 PM- 3-11 and don/off 6-8 hours. Nurse #5 also stated the expectation was for nursing to apply and document when the splints were applied and check behind the aides to make sure the splints were in place. Nurse #5 stated she documented that the splints were applied on 4/27/21, when asked did she apply them herself and the response was she could not recall. Nurse stated she could not be certain when the splints were being applied or removed. Interview on 4/28/21 at 10:46 AM, the Physical Therapy Director (PTD) stated staff were trained and instructed on how to apply splints and Resident #31 had been referred to the restorative program following the completion of his therapy services. The PTD also stated the restorative program was not currently functional at this time. The PTD stated nursing was responsible for ensuring the residents were wearing the splints	F 688		

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as ordered.

Interview on 4/28/21 at 3:22 PM, the Director of Nursing (DON) stated the process should be the therapy department develop the restorative program and splint application, Rehab would train the nurse aides and nurses on the requirements and frequency of the splint application. The nurse aide was responsible for documenting in the POC when the splint was applied. Nursing was expected to go into room and check for application and document on the Medication Administration Record (MAR) that it was done.

Follow-up observation on 4/28/21 at 3:30 PM with Nurse #2, Observation of Resident #31 in room without elbow/hand splints. The elbow splint was found under several personal hygiene items and personal clothing in a wheelchair. Nurse #2 stated she had not been trained on the application of the splints. Resident #31 provided staff instructions on how to apply the elbow splint and the hand splint was not available. Nurse #2 stated the splints should have been on since 7:30 AM, not sure why staff had not applied the splints. Resident #31 confirmed the splint had not been applied at any point during the day.

Follow-up interview on 4/28/21 at 3:45PM, NA#3 stated he thought therapy was going to apply the splint, he confirmed he did not apply the splint during 7- 3pm.

Interview on 4/29/21 at 9:23 AM, NA#4 stated she had worked with the Resident #31 on 4/26/21 and did not apply the splints on resident during the 7:30 AM-3 shift. She further stated she had been trained on how to apply splint on resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 11 Interview on 4/29/21 at 12:52 PM, the Administrator stated he expected the staff to follow therapy orders for splint application and restorative program.	F 688		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, staff and record review, the facility failed the facility failed provide spill proof cup and adaptive utensils for 1 of 2 sample residents (Resident #41) reviewed for feeding assistance. The findings included: Resident #41 was admitted to the facility on 5/1/18. The diagnoses included dysphagia, right eye blindness, glaucoma, end stage renal disease, diabetes and hypertension. The quarterly Minimum Data Set (MDS) dated 3/1/21, indicated Resident #41 had cognition impairments and required total assistance with activities of daily living. Review of the revised plan of care dated 3/03/2021, identified the problem as Resident #41 had alteration in vision related to glaucoma with blindness. The goal included Resident #41 would be able to feed self- meals with set up and cueing as needed. The approaches included he would use adaptive devices/equipment, keep items in	F 810	Description of the Deficient Practice Based on observation, staff and record review, the facility failed to provide spill proof cup and adaptive utensils for 1 of 2 sample residents (Resident #41) reviewed for feeding assistance. Corrective Action for those Residents found to have been affected Resident #41 admitted to the facility on 5/1/2018 and is at baseline. Facility has reviewed Resident #41□s care plan, medical record, meal card, and physicians□ orders pertaining to adaptive feeding devices. Corrective Action to identify potential affected residents The facility has conducted an audit of all resident□s requiring adaptive eating devices ensuring the following: 1) physician□s order for adaptive device; 2)	6/7/21

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F 810	Continued From page 12 same place and place objects within reach. Observation on 4/27/21 at 12:40 PM, Resident #41 ' s meal was set up by Minimum Data Coordinator (MDS) #2. The meal card documented Resident #41 required buildup adaptative utensils, buildup, spill proof cup and yellow divided plate. There were no adaptive utensils or cup provided on the tray. Resident #31 was provided with regular utensils and regular cups. The meal tray had lemon tea, water, 2 cans of coke. The meal consisted of 2 pieces of fried chicken wings, carrots and beans served in sectional plate and fruit cocktail. The staff applied straws to all the fluids. Resident #41 had some difficult lifting cups and cans of soda due shaking and poor grip to hold the cup or can of soda due visual impairments. Staff left the room without checking the meal card to ensure resident had all required adaptive utensils or cup. Interview on 4/27/21 at 12:52 PM, Nurse Aide #1 observed resident's meal tray and confirmed the resident was not provided with the spill proof cup and built up utensils. NA#1 stated the staff setting up residents were expected to review the meal card to ensure the resident receive items on the meal card. NA#1 also confirmed during the breakfast observation the resident did not have the spill proof cup and the staff who set up the resident did not check the meal card for accuracy. Interview on 4/27/21 at 1:03 PM, the MDS #2 staff stated she did not review the resident's meal card to ensure the resident had the proper adaptive utensils as listed on the card. She stated she was focused on whether the resident had the proper diet. MDS#2 confirmed the resident fluids were	F 810	evaluate need of resident education and assistance on use of adaptive feeding devices; 3) adaptive devices are clearly noted on their meal card, medical record and care plan Ongoing Corrective Action The facility has reviewed its policies on Adaptive Eating Devices and Tray Card System. Nursing and Dietary staff will be in-serviced on Adaptive Eating Devices and Tray Card System policies. The dining services department is responsible for ensuring that each individual received the appropriate feeding devices for each meal. Monitoring Plan QA The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) All newly admitted residents are reviewed on admission and periodically to assess the need for adaptive devices. 2) All residents requiring adaptive eating devices will be monitored during various mealtimes x5 days weekly x4 weeks and weekly x3 months; confirming each individual resident receives the appropriate feeding devices for each meal. Results will be presented by the Certified Dietary Manager and/or the Administrator to the QA team monthly. Findings will be addressed promptly by the QA team. After	

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F 810	Continued From page 13 provided in a regular cup there were no adaptive utensils provided. Interview on 4/27/21 at 1:34 PM, the Dietary Manager (DM) stated kitchen staff was responsible for ensuring resident meal cards and trays were accurate prior to delivery to the resident. The food line staff consist of 3 individuals that was responsible for checking resident diet for accuracy, checking to ensure supplements and adaptive utensils were placed on the tray. If there was an item missed the unit staff were expected to call to the kitchen to make sure the missing items were available. Interview on 4/27/21 at 1:45 PM, the Nurse #1 stated the expectation was for all staff that set up resident ' s trays should check resident meal card for accuracy of diet, special instructions, likes/dislikes, supplements and adaptive utensils. Staff should contact the dietary staff immediately and get the correct items for the resident. Staff should also assist the resident with opening food and beverages. Interview on 4/28/21 at 8:14 AM, the Director of Nursing stated she expected the staff who are setting up residents to review the meal card to ensure the resident's diet is accurate, all special instructions were reviewed, supplements and adaptive equipment was provided on the tray. Residents should be assisted with opening food/beverage products and helped with meal prior to leaving the room. Staff expected to contact the kitchen for any items missing from the tray. Interview on 4/29/21 at 12:52 PM, the Administrator stated staff that were assisting	F 810	the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date for Correction June 7, 2021	

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F 810	Continued From page 14 residents with meal setup were expected to check and review the meal card and ensure the residents received the accurate diet, supplements, adaptive utensils and cups as ordered.	F 810		
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 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 record review, observation and interviews, the facility failed to keep clean and failed to label and date food for 1 of 2 nourishment refrigerator/freezers reviewed for food storage (400-hall). Findings included: Review of the "patients/resident's personal food	F 812	Description of the Deficient Practice Based on record review, observation and interviews, the facility failed to keep clean and failed to label and date food for 1 of 2 nourishment/freezer reviewed for food storage (400-hall) Corrective Action for those Residents	6/7/21

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F 812	Continued From page 15 policy" dated 1/9/18 read in part "family members/friends may bring food into the healthcare center for their individual family member's consumption. Food requiring refrigeration must be labelled and dated and will be discarded after 48 hours. Frozen foods must be labeled and dated and will be discarded after 14 days." On 4/27/21 at 12:03 PM an observation of the nourishment refrigerator/freezer on the 400-hall revealed the refrigerator contained nutritional supplements and multiple 4 oz (ounce) juice cups. Yellow stains, and spilled orange liquid were observed on the floor of the refrigerator. The refrigerator inside door storage area also revealed spilled orange liquid. The freezer revealed an 8 oz cola can, which had broken open due to freezing and brown stains were observed in that area. The freezer also contained a 16 oz plastic cup with yellow colored frozen liquid, a 16 oz styrofoam cup with a creamy colored frozen liquid from a fast-food restaurant, and two frozen dinner containers that were not labeled or dated. The freezer floor had yellow and brown stains on it. During an interview on 4/27/21 at 12:05 PM, Nurse #2 stated the dietary staff were responsible to clean the nourishment refrigerator. The nurse further stated the food in the nourishment freezer belonged to the residents. The nurse added that resident's food should be labeled and dated prior to being placed in the nourishment refrigerator. Nurse #2 was unable to identify which resident the food belonged to. During an interview on 4/27/21 at 2:08 PM, the dietary manager stated the assistant dietary	F 812	found to have been affected Food was discarded from the nourishment/freezer on the 400 hall Corrective Action to identify potential affected residents Facility has audited all designated resident food storage refrigerators/freezers ensuring that: 1) all items are labeled and dated; 2) items discarded according to their use by date; 3) clean and sanitary environment/equipment; 4) resident items only are stored in the nourishment refrigerators. Ongoing Corrective Action Nursing and Dietary staff have been educated to the facility Nourishments policy. Nursing staff have been educated that the nourishment room refrigerator should be used to store resident items only. Staff may use the refrigerator located in the break room for personal items. Signs have been posted in the nourishment rooms to further communicate this. The Dietary department will be responsible for ensuring: 1) nourishment kitchens and equipment are clean and sanitary; 2)food/drink items are properly labeled and dated; 3) only permissible food/drink items are stored in nourishment refrigerators. Monitoring Plan QA	

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F 812	Continued From page 16 manager was responsible to make sure the nourishment refrigerators were cleaned and stocked daily. During an interview on 4/28/21 at 2:03 PM, the assistant dietary manager stated she was responsible to clean the nourishment refrigerators. The assistant dietary manager indicated the nourishment refrigerators were cleaned daily, the tray containing resident's night snacks was removed, and expired food and milk were discarded. The resident's snacks brought in by the family members were to be labelled and dated by the nursing staff prior to being placed in the nourishment refrigerators. During an interview on 4/29/21 at 1:48 PM, the Administrator stated the nourishment refrigerators should be cleaned daily. The Administrator further stated the resident's food should be labelled and dated prior to being placed in the nourishment refrigerators. Staff should follow policy related to resident's food brought in by their families.	F 812	The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) All nourishment rooms will be audited by the CDM or designee x2 daily x7 days per week ensuring sanitary food practices. Results will be presented by the Certified Dietary Manager and/or the Administrator to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date for Correction June 7, 2021	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain one of one walk-in freezer in safe operating condition. The kitchen's walk-in freezer had accumulated ice on the freezer floor and on food stored inside the freezer. There was a pile of ice outside the freezer.	F 908	Description of the Deficient Practice Based on observations and staff interviews the facility failed to maintain one of one walk-in freezer in safe operating condition. The kitchen□s walk-in freezer has accumulated ice on	6/7/21

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Continued From page 17

Findings included:

An observation of the walk-in freezer on 4/26/21 at 9:30 AM revealed the internal temperature was 0 degrees Fahrenheit as indicated by the thermometer inside the freezer. The built-in thermometer on the outside of the walk-in freezer indicated 30 degrees Fahrenheit. The freezer door had a weather strip on the door frame, that was covered in ice. This was preventing the door to close tightly and completely. Observations inside the freezer revealed there was a thin layer of ice on the freezer's floor. The freezer's compressor had a huge icicle hanging from it and a thick layer of ice covering it. All the racks in the freezer had icicles and ice on them. Observation of the boxes of food placed under and beside the freezer compressor revealed the boxes had a layer of ice on them. Four - 3 lbs. (pounds) bags of vegetables, twelve brown carboard boxes containing food , a 2 lbs. cardboard box labelled " Eggo's frozen waffles", a brown cardboard box labelled angle food cakes and a white plastic container were observed to be covered in a layer of ice. Labels were not clearly visible as these were covered in ice. The dietary manager indicated the white plastic container had strawberries in them. Five unlabeled cardboard boxes that was stored on the rack closer to the freezer's door were observed to be wet. The dietary manager indicated these boxes contained frozen food. Outside the freezer in the hallway was a small pile of ice.

During an interview on 4/26/21 at 9:35 AM, Dietary Manager (DM) indicated around the end of September 2020 and beginning of October 2020, the main walk in freezer began developing

F 908

the freezer floor and on food stored inside the freezer. There was a pile of ice outside the freezer.

Corrective Action for those Residents found to have been affected

New walk-in freezer has been ordered.

Corrective Action to identify potential affected residents

The facility has ordered a replacement Walk in Cooler / Freezer combination unit on 4/29/2021 to be furnished and installed by R&S Mechanical. Deposits have been made to secure the replacement unit installation. Vendor has ordered the replacement walk-in unit and estimates an installation date between 6/21/2021 - 7/12/2021. Facility is temporarily utilizing a True brand 3-door reach-in freezer as supplemental food storage to meet facility food storage needs until replacement walk-in unit is installed and in safe operating condition.
The facility has audited all dietary essential equipment ensuring that: 1) equipment is in safe operational condition 2) areas used to prepare resident meals are maintained as a clean and sanitary environment

Ongoing Corrective Action

The facility has reviewed its policy on Cleaning Procedures: Major Equipment. CDM, Maintenance, and dietary staff have been educated on the facility Cleaning

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F 908	Continued From page 18 some light ice buildup around the door. Staff were able to easily remove any build up and there was no buildup of ice on food items at that time. The DM stated in mid-October 2020, the maintenance director had contacted a contracted repair company to fix the issue. The DM further stated the contractor had informed them that the heater seal around the door was not functioning in a small area around the door. The contractor also informed the facility that the unit was too old to find a replacement part. A new unit quote was provided by the outside contractor on 10/28/20. The DM added the walk-in freezer continued to have ice buildup that was easily removed and cleaned by the staff. The DM indicated in December 2020 (12/24 20) the facility's administrator submitted a corporate request (CER) to the corporate office for the freezer to be replaced. The DM further indicated about 4-6 weeks ago the ice buildup in the freezer started becoming much worse, ice had slowly began building up within the door frame itself which kept the door from sealing properly. The DM stated a three-door reach-in freezer was obtained from a sister facility and this was utilized to store much of the frozen goods, as possible. The DM further stated over the weekend the three-door reach in freezer also began having ice buildup and the dietary staff had to move the frozen food items back into the old freezer. The maintenance director had shut down the reach in freezer on the morning of 4/26/21. The drain line in the reach-in freezer came loose and had frozen, creating an ice buildup in the reach-in freezer. The three-door reach- in freezer remained switched off the remainder of the day to allow the drainpipe to thaw. The DM manager stated that once the maintenance staff had completed the repair and approves the reach-in freezer for use, it was the	F 908	Procedures: Major Equipment policy. All staff have been in-serviced on facility process and procedure for submitting work orders in Building Engines ensuring all essential equipment is operating properly and that any equipment malfunction issues are promptly addressed. Preventative Maintenance for the walk-in freezer is completed by Maintenance Department monthly and quarterly to ensure the equipment is in safe operational condition. Monitoring Plan QA The LNHA is responsible for the Plan of Correction implementation. The QA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) Facility CDM, Maintenance Director or designee will audit all dietary essential equipment weekly x4 and then monthly x3 ensuring that all equipment is in safe operational condition and areas used to prepare residents meals are maintained as a clean and sanitary environment. Results will be presented by the LNHA to the QA team monthly. Findings will be addressed promptly by the QA team. After the conclusion of the ongoing monitoring as described above, the QA team will determine the frequency of ongoing monitoring. Date for Correction June 7, 2021	

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F 908	Continued From page 19	F 908		

intent to again utilize the reach-in freezer to store as much frozen goods as possible.

Observation of the three-door reach-in freezer on 4/26/21 at 9:40 AM, revealed there was ice on the floor of the reach-in freezer. The freezer was empty and there was no indication of temperature on the freezer. The reach-in freezer was shut down.

During an interview on 4/28/21 at 8:00 AM, the maintenance personnel indicated he was aware of the issue with the walk-in freezer. The maintenance personnel stated the freezer door was not closely properly. The freezer was maintaining temperature below zero, however when the outside air entered the freezer, it caused a snowing effect in the freezer. The maintenance personnel stated between September and October 2020 multiple repairs were done to the refrigerator. The facility had contacted an outside contractor for repairs. The door gasket was replaced, a heat strip added and a new rubber seal around the door was placed to make sure the freezer door was closed properly. The maintenance personnel further stated the air was getting in the door and the door was not shutting well. The maintenance personnel indicated the contractor had recommended buying a new freezer. The maintenance personnel stated the facility had brought in a three-door reach-in freezer from their sister facility a few weeks ago. The metal door of the reach-in freezer had some issue and the drainpipe was not fitted well. This resulted in the drainpipe becoming frozen and ice on the floor. The three-door reach-in freezer was shut off so that the drainpipe could be defrosted, and appropriate repairs completed.

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F 908	Continued From page 20 During an interview on 4/29/21 at 1:48 PM, the administrator stated he was aware of the sealing issue with the walk-in freezer. The facility had multiple vendors come in to do the repairs, but it was just a temporary fix. The administrator further stated a corporate request (CER) for a new freezer was completed in December 2020. The administrator added the corporate office had approved for a new walk-in freezer unit on 4/29/21.	F 908		