STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345225	A. BUILDING _____ B. WING _____	C 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

(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 The survey team entered the facility on 8/30/21 to conduct a recertification survey. The survey team was onsite 8/30/21 through 9/2/21. Additional information was obtained offsite 9/2/21 through 9/7/21 . Therefore, the exit date was 9/7//21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # C8Q311.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 8/30/21 to conduct a recertification and complaint survey. The survey team was onsite 8/30/21 through 9/2/21. Additional information was obtained offsite 9/3/21 through 9/7/21. Therefore, the exit date was 9/7/21. 3 of the 22 complaint allegations were substantiated. Event ID # C8Q311.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		10/5/21

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

Electronically Signed | 09/29/2021

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F 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to care plan the use of psychotropic medications for 1 of 5 residents reviewed for psychotropic medication use (Resident #47). The facility additionally failed to implement interventions identified on the care plan for 1 of 6 residents reviewed for activities of daily living (Resident #38). Findings Included: 1.Resident #47 was admitted to the facility on 6/11/21 with diagnoses that included Alzheimer ' s Disease, restlessness and agitation, psychosis	F 656	F656 1. Comprehensive care plan updated to reflect psychotropic medication use for resident #47. Resident #38 is no longer in the facility however his mittens were applied prior to resident discharge. 2. All residents had the potential to be affected. Care plans will be reviewed, revised and updated for current resident population receiving psychotropic medications by 9/24/21. Additionally, observation and validation will be made of the current resident population to ensure care planned interventions are in place for	

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F 656	Continued From page 2 and depression. Review of the physician ' s orders for Resident #47 revealed he received Zoloft (an antidepressant) 100 milligrams (mg) every day, Trazadone (an antidepressant) 50 mg every day and Seroquel (an antipsychotic) 25 mg every 12 hours. Review of an admission minimum data set (MDS) dated 6/18/21 for Resident #47 identified he received an antipsychotic and an antidepressant for 7 days during the look-back period. Review of the care area assessment (CAA) dated 6/24/21 for Resident #47 revealed to proceed to care plan for the use of psychotropic medications. The care plans for Resident #47 were reviewed and no plan of care had been developed for the use of psychotropic medications. An interview on 9/2/21 at 3:03 pm with the MDS Nurse revealed a care plan should have been developed for the use of the antipsychotic and antidepressant medications as indicated in the CAA. She stated she would develop these care plans. An interview with the Administrator on 9/7/21 at 1:40 pm revealed he expected the use of psychotropic medications to be care planned. 2. Resident #38 was admitted to the facility on 7/9/21 with diagnoses that included Smith-Lemli-Opitz syndrome, convulsions, tracheostomy and gastrostomy status, loss of vision to both eyes and abnormal posture.	F 656	each resident. Newly admitted residents on psychotropic medications will have a care plan initiated to reflect psychotropic medication use and care planned interventions validated to verify they are in place. 3. Education on the comprehensive care plan policy to include validating interventions are in place was provided by the Regional Clinical Reimbursement Specialist to the MDS Nurses by 9/24/2021. Additional education will be provided to the Licensed Nurses by 10/01/2021 by the SDC. This training will also be provided to all MDS coordinators and Licensed Nurses upon hire during orientation. 4. Ongoing audits will be conducted by the Regional Clinical Reimbursement Specialist for observation and review to ensure psychotropic medication usage is accurately coded on the MDS assessments for each resident. Additional audits will be conducted by the DON, ADON and/or Unit Manager to validate care planned interventions are in place upon facility rounds. These audits will be conducted on 10 residents twice a week for four weeks, 5 residents weekly for three weeks, then 5 residents monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee	

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F 656	Continued From page 3 An admission minimum data set (MDS) dated 7/16/21 for Resident #38 identified he had severely impaired vision, was totally dependent for personal hygiene and his cognition was severely impaired. Review of the care plans for Resident #38 revealed a care plan dated 8/6/21 stating the resident had non-voluntary movements and he dug in both of his eyes. Interventions included for the resident to always wear his protective gloves. An observation of Resident #38 on 8/30/21 at 11:20 am revealed the resident was poking himself with his fingers in his right eye and both eyes were very red. No gloves were observed to be on the resident ' s hands. An observation of Resident #38 on 8/31/21 at 10:00 am revealed the resident did not have any gloves on his hands. He was repeatedly poking at both of his eyes with his hands. An observation on 9/1/21 at 12:00 pm revealed the resident was poking his fingers into both eyes repeatedly. No gloves were observed to be on the resident ' s hands. An interview with Nursing Assistant (NA) #1 on 9/1/21 at 12:15 pm revealed he was providing care for Resident #38. He stated the resident did poke at his eyes continually and they tried to keep a pair of eyeglasses on him, but the resident could remove them. He added he did not know anything about the resident wearing protective gloves. An interview on 9/2/21 at 2:02 pm with the Director of Nursing (DON) revealed Resident #38	F 656	consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and MDS Coordinator is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 5, 2021.	

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F 656	Continued From page 4 ' s family member had suggested they keep gloves on his hands because he repeatedly would poke his fingers in his eyes and he also would chew on his fingers. She stated if the resident ' s care plan indicated he should always wear gloves then he should have had them on. An interview with the Administrator on 9/7/21 at 1:40 pm revealed he expected the staff to follow the interventions identified on their care plans.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide nail care for 1 of 6 dependent residents reviewed for activities of daily living (Resident #38). Findings Included: Resident #38 was admitted to the facility on 7/9/21 with diagnoses that included Smith-Lemli-Opitz syndrome, convulsions, tracheostomy and gastrostomy status, loss of vision to both eyes and abnormal posture. An admission minimum data set (MDS) dated 7/16/21 for Resident #38 identified he was totally dependent for personal hygiene and his cognition was severely impaired. Review of the care plans for Resident #38	F 677	F677 1. Nail care was provided for Resident #38 on 9/1/21. 2. All residents had the potential to be affected. An audit of the current resident population was completed determine the need for nail care. Nail care was provided for all identified residents by 9/28/2021. Newly admitted resident will be assessed for the need for nail care and will be provided as needed. 3. Education on nail care was provided to the licensed nurses and the certified nursing assistants. This education will be completed by 10/01/2021. This training will also be provided to all licensed nurses and certified nursing assistants upon hire during orientation. 4. Ongoing audits will be completed by	10/5/21

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F 677	Continued From page 5 revealed a plan of care dated 7/12/21 that identified a self-care deficit related to cognitive impairment and blindness. The interventions included to provide activities of daily living (ADLs) daily to ensure daily needs were met. A care plan dated 8/6/21 revealed the resident had non-voluntary movements and he dug in both of his eyes. Interventions included for the resident to always wear his protective gloves. An observation of Resident #38 on 9/1/21 at 12:00 pm revealed the resident was in bed and he was poking himself repeatedly in the eyes. His fingernails on both hands were observed to be approximately 1 to 2 inches long and jagged. The resident did not have on protective gloves. An interview with Nursing Assistant (NA) #1 on 9/1/21 at 12:15 pm revealed he was providing care for Resident #38. He stated the resident required total care and typically nail care was provided with morning care and on shower days. He stated the resident did not refuse care and his nails were long and needed to be cut. NA #1 explained the resident did poke at his eyes continually and they tried to keep a pair of eyeglasses on him, but the resident could remove them. He added he did not know anything about the resident wearing protective gloves. NA #1 stated he would provide nail care for the resident. An interview on 9/2/21 at 2:02 pm with the Director of Nursing (DON) revealed Resident #38 did poke his fingers in his eyes repetitively and he also would chew on his fingers. She stated the resident was totally dependent on staff for nail care and the nursing staff should ensure that his nails were trimmed.	F 677	the Director of Nursing, Assistant Director of Nursing and/or the Staff Development Coordinator for observation and validation that nail care has been provided. These audits will be conducted twice a week for four weeks, weekly for three weeks, then monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 5, 2021.	

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F 677	Continued From page 6 An interview on 9/7/21 at 1:40 pm with the Administrator revealed it was his expectation that residents were well groomed including having their nails trimmed.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		10/5/21

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F 690	Continued From page 7 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to have physicians ' orders for an indwelling urinary catheter and orders for how to care for the catheter. This was evident for 1 of 1 resident reviewed for the use of an indwelling urinary catheter (Resident #32). Findings Included: Resident #32 was admitted on 6/16/21 and diagnoses included a stage 4 pressure ulcer to her sacrum and urinary tract infection. A care plan with an initiation date of 6/22/21 for Resident #32 identified she was at risk for infection related to an indwelling catheter. A quarterly minimum data set (MDS) dated 7/6/21 for Resident #32 identified he had an indwelling urinary catheter, was totally dependent for toilet use and had significantly impaired cognition. Review of the physician ' s orders for Resident #32 from admission date of 6/16/21 through 9/1/21 revealed no orders for the indwelling urinary catheter or orders for how to care for the catheter. An observation on 8/30/21 at 1:53 pm of Resident #32 revealed she was lying in bed and an indwelling urinary catheter was present. An observation on 9/2/21 at 9:05 am of Resident #32 revealed a #16 French indwelling urinary	F 690	F690 1. Physicians 'orders for an indwelling urinary catheter and orders for how to care for the catheter were implemented on 9/2/2021 for resident #32. 2. Residents with the potential to affected have been identified. An audit of the identified residents was completed to validate the presence of physicians' orders for an indwelling catheter and order for how to care for the catheter by 9/24/2021. Newly admitted residents with indwelling urinary catheters will have physicians' orders initiated for the indwelling urinary catheter along with orders for how to care for the catheter. 3. Education on initiating physicians order for residents with indwelling urinary catheters to include orders for how to care for the catheter was provided to the licensed nurses by 10/01/2021. This training will also be provided to all licensed nurses upon hire during orientation. 4. Ongoing audits will be completed by the Director of Nursing, Assistant Director of Nursing and/or the Staff Development Coordinator for observation and validation that physician orders have been implemented for residents with indwelling urinary catheters to include orders for how to care for the catheter. These audits will be conducted twice a week for four weeks, weekly for three weeks, and then	

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F 690	Continued From page 8 catheter. An interview on 9/2/21 at 2:23 pm with the Director of Nursing (DON) revealed no orders had been obtained for the indwelling catheter for Resident #32 on admission. She stated this was missed when admitting the resident. The DON stated orders were received from the physician today for the catheter size, flush for leakage or blockage and for catheter care.	F 690	monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 5, 2021.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the responsible party (RP) of a physician's appointment for 1 of 3 residents (Resident #77). Findings included:	F 745	F745 1. Responsible party for Resident # 77 has been notified of physicians' appointment. 2. All residents have the potential to be affected. In house audit completed on current resident population for the last 30	10/5/21

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F 745	Continued From page 9 Resident #77 was admitted to the facility on 5/25/19 with diagnoses that included schizophrenia, epileptic seizures, cognitive communication deficit, muscle weakness, repeated falls, and unspecified dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated 8/6/21 revealed Resident #77 had severe cognitive impairment and required limited to extensive assistance with transfers and activities of daily living. Review of records revealed Resident #77 had an order written by the facility Nurse Practitioner on 6/1/21 for a referral to Gastrointestinal (GI) for chronic intestinal pseudo-obstruction with a retained foreign body. Review of records revealed Resident #77 was transported from the facility to a GI Physician appointment on 8/19/21 at 9:30 am. The purpose of the visit was to evaluate his chronic small bowel obstruction with a retained foreign body. The instructions listed on the after visit summary included a computed tomography of the abdomen and pelvis to be scheduled to evaluate the anastomosis and location of foreign bodies. The results of this scan would determine if a colonoscopy for anastomosis dilation and retrieval would be indicated. There was a handwritten note on the after visit summary that indicated the computed tomography was scheduled for 9/10/21 at 7:00 am. During an interview with the facility scheduler on 9/2/21, she revealed she coordinated residents' appointments and transportation. She stated she transported Resident #77 to his GI physician	F 745	days to ensure proper notification has been made to the responsible parties of residents that have had a physician's appointment by 9/30/2021 by the DON, SDC, ADON and/or Unit Manager. Going forward, the unit secretary will be responsible for notifying the resident/responsible party of physicians' appointments. Newly admitted residents with physicians' appointments will have responsible party notification by the unit secretary. 3. Education on responsible party notification for residents with physician appointments was provided to the scheduler and the licensed nurses by 10/01/2021. This training will also be provided to all schedulers and licensed nurses upon hire during orientation. 4. Ongoing audits will be completed by the Director of Nursing, Assistant Director of Nursing and/or the Staff Development Coordinator for observation and validation that responsible party notification has been made and documented for residents with physician appointments. These audits will be conducted 5 x a week for two weeks, weekly for two weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS	

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F 745	Continued From page 10 appointment on 8/19/21. The scheduler stated she did not contact Resident #77's RP about this appointment or the after visit summary instructions. The scheduler stated the process for appointments was the nurses received orders for referrals and she arranged the date and time for the transport. The scheduler further stated it was the nurses' responsibility to contact the RP for resident referrals to physician appointments. An interview with the nurse who placed and verified the referral order was unsuccessful. An interview with the responsible party was unsuccessful. During an interview conducted with the Administrator on 9/2/21, he revealed the scheduler was responsible for contacting the RP to notify of upcoming offsite appointments. He indicated that the scheduler should have contacted the RP about Resident #77's physician appointment.	F 745	coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 5, 2021.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by:	F 806		10/5/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF CHAPEL HILL	1602 E FRANKLIN STREET CHAPEL HILL, NC 27514

(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 806	Continued From page 11 Based on record review and staff interviews the facility failed to honor food preferences for 1 of 3 residents (Resident #293). Findings included: Resident #293 was admitted to the facility on 1/7/21 with diagnoses that included type II diabetes, wound, hypothyroidism, chronic kidney disease, hypertension, and congestive heart failure. She was discharged on 2/4/21. Review of the admission Minimum Data Set (MDS) assessment dated 1/14/21 revealed Resident #293 was cognitively intact and required extensive assistance with activities of daily living and supervision with meals. Review of admission physician orders dated 1/7/21 revealed Resident #293 had an order for a regular diet. There were no restrictions or special instructions noted in the diet order. Review of Social Worker (SW) progress notes dated 1/22/21 revealed there was a care plan conference conducted on the same date with the SW, Director of Nursing, Wound Care Nurse, family representative, and Resident #293 in attendance. Topics discussed were wound status and care, therapy, and concerns with food provided on breakfast trays. Resident #293 stated she had received items on her breakfast trays that she did not like and would rather have fruit and cereal. The Director of Nursing and the Wound Care Nurse explained to Resident #293 that she needed some protein that would help with wound healing. Resident #293 agreed to	F 806	F806 1. Resident #293 has discharged from the facility. 2. All residents have the potential to be affected. Residents residing in the facility had their food preferences reviewed and updated by the Dietary Manager on or before 9/30/2021 using the Food Preference Interview form. Newly admitted residents will have their food preferences reviewed and updated using the Food Preference Interview form. Food preference request will be made to the dietary department and the Registered Dietician using the Dietary Communication Form. 3. Education on resident food preferences was provided to the Dietary Manager and the dietary staff by the Regional Dietary Manager on or before by 10/02/2021. This training will also be provided to all dietary managers and dietary staff upon hire during orientation. 4. Ongoing audits will be completed by the Regional Dietary Manager, Dietary Manager and/ or Administrator to audit one resident's food preference on each unit to validate food preferences are honored and resident preferences have been communicated to the dietary staff and the RD. These audits will be conducted 3 x week for two weeks, weekly for two weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends	

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F 806	Continued From page 12 have boiled eggs when served for breakfast. Review of the grievance log from 12/1/20 to 8/30/21 revealed there were no concerns documented for food preferences or requests from Resident #293 or any other residents. During an interview with the dietary manager on 9/1/21 at 2:05 pm, she revealed Resident #293 had a regular diet with no special preferences noted in her orders. She indicated there were orders for a supplement for wound healing. The dietary manager also indicated that Resident #293 ate 75 to 100% of her meals most of the time. She indicated that Resident #293 ate oatmeal, grits, eggs and a meat for breakfast. She also indicated the meat served for breakfast was usually sausage or bacon. The dietary manager was unaware that Resident #293 had requested preferences or substitutes for her breakfast trays. During an interview on 9/2/21 at 2:28 pm with a Nurse Assistant that cared for Resident #293, it was revealed that Resident #293 voiced to staff that she did not care for bacon or grits on her breakfast trays. The Nurse Assistant indicated she communicated this to the kitchen but did not recall documenting this request anywhere. During an interview with the SW on 9/2/21 at 9:50 am, she revealed she recalled the care plan conference on 1/22/21with Resident #293 and reviewed the progress note she wrote. She stated when a resident voiced a concern or requested a substitute for their meals, this would be communicated on a ticket to the dietary manager. The SW was not certain if this request was communicated to the dietary manager or the	F 806	identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Dietary Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 5, 2021.	

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F 806	Continued From page 13 kitchen by anyone present in the care plan conference. During a phone interview on 9/7/21 at 10:42 am with the Register Dietician (RD), she revealed she was unaware that Resident #293 had requested a substitute or healthier options on her breakfast trays. She stated she was aware that Resident #293 had a diagnosis of diabetes and she would not have automatically placed Resident #293 on a carbohydrate modified diet when she was admitted. The RD indicated that she placed residents on a liberalized diet until she further assessed residents that needed their diets modified. The RD stated she monitored Resident #293's blood sugars and food intakes. The RD also confirmed that Resident #293 was on a regular diet and she was not aware that Resident #293 had made food preference requests for healthier options. The RD further stated if a resident made a food request she would get that information from the dietary manager. During a phone interview conducted with the Administrator on 9/3/21 at 11:05 am, he indicated residents should have their food preferences honored to the best of the facility's ability.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		10/5/21

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F 812	Continued From page 14 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to discard expired food items, failed to allow steamtable pans to air dry, failed to clean the convection oven and failed to properly seal opened food items. This was evident for 1 of 1 kitchen observations. Findings Included: An observation of the kitchen on 8/30/21 at 10:15 am was conducted with the Dietary Manager (DM) and revealed the following: 1. The dry storage room contained 1 case of honey thick orange juice with an expiration date of 3/4/21, 1 case of honey thick cranberry juice with an expiration date of 5/11/21, 2 cases of honey thick apple juice with an expiration of 8/13/21 and 2 cases of honey thick tea and 1 case of honey thick cranberry juice with expiration dates of 8/29/21. The DM stated all of these products would be thrown away and should have been removed from the storage room by there expiration dates. She added there were no resident ' s currently receiving honey thick liquids.	F 812	F812 1. The items being stored out of date were discarded immediately, the convention oven was cleaned, the steamtable pans were separated and air-dried, and the open food items were discarded. 2. All residents had the potential to be affected. The Dietary Manager and the Regional Dietary Manager completed an inspection of all food storage areas to identify items being stored out of date, opened food items along with validating the convection oven was cleaned and the steamtable pans were dried. 3. Education on the Food Storage policy will be conducted with the Dietary Staff by 9/28/21 by the Regional Dietary Manager. Education on the proper method to store the steamtable pans, storing open food items and cleanliness of the convection oven will also be conducted with the Dietary Staff by 10/01/2021 by the Regional Dietary Manager. This training will also be provided to all Dietary Staff upon hire during orientation. 4. Ongoing audits by the Administrator,	

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F 812	Continued From page 15 2. 4 full size steamtable pans were stacked together wet on a storage rack. The DM confirmed this was the storage rack for clean / dry pans and the staff should not have stacked them together until they had dried. 3. Upon opening the convection oven there were blackish / gray dry particles floating in the oven. There was a steamtable pan of uncovered rice in the oven. Dried food spills and a liquid grease like substance were present. The DM stated she thought the particles were coming from the rice. She added they typically cleaned the convection oven once a month and she would get it cleaned by the end of the week. 4. The walk-in freezer contained a 20-pound case of mixed vegetables that was open, and the vegetables were exposed to the air. The DM stated the staff should re-seal the bags after they opened them. An interview with the Administrator on 9/7/21 at 1:40 pm revealed he expected food to be used or discarded by the expiration date; he expected the convection oven to be clean, he expected the steamtable pans to be allowed to air dry and that open foods would be placed in resealable bags.	F 812	Registered Dietician, Dietary Manager, and Regional Dietary Manager will be conducted for observation and review of all facility for food storage areas, the convention oven, and the steamtable pans. These audits will be conducted 5 times a week for two weeks, weekly for two weeks, and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise, and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Dietary Manager is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 5, 2021.	