STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345268	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MARSHVILLE	311 W PHIFER STREET MARSHVILLE, NC 28103

(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 infection control survey was conducted 11/1/2021 to 11/4/2021. The facility was found in compliance with requirement CFR 483.73, Emergency Preparedness. Event ID # VETR11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification, revisit investigation and complaint investigation was conducted 11/1/2021 to 11/4/2021. There were 11 allegations investigated and 3 were substantiated. Event ID: VETR11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/6/21

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

Electronically Signed | 11/24/2021

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to provide a cover over a urinary drainage bag for 1 of 2 residents, Resident #184, reviewed to ensure the residents were treated in a dignified manner. Findings included: Resident #184 was admitted to the facility on 10/25/2021 with diagnoses of urinary obstruction and kidney failure. An Admission Minimum Data Set assessment had not been completed but was in progress. A Physician's Order dated 10/25/2021 stated Resident #184 required a urinary catheter and a privacy cover should be provided. A Care Plan dated 10/25/2021 stated Resident #184 had a diagnosis of urinary obstruction and	F 550	*The Director of Nursing place a privacy bag over R #184's urinary catheter bag on November 4, 2021. *All other residents who utilize a urinary catheter bag were audited by the Director of Nursing. One of nine residents did not have a privacy bag over her urinary catheter bag. The Director of Nursing placed a privacy bag over it on November 8, 2021. *The nursing staff were reeducation on residents rights related to ensuring a privacy bag is placed over any urinary catheter bag. This education was done by the Director of Nursing and the Staff Development Coordinator. The education as completed on November 19, 2021. *Audits of residents who utilize a urinary catheter bag will be conducted weekly for three weeks then monthly for three	

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F 550	Continued From page 2 required an indwelling catheter. The Care Plan further stated staff should ensure Resident #184's urinary drainage bag was covered for dignity. During an observation of Resident #184 on 11/1/2021 at 11:41 am he was up in his reclining wheelchair and was placed in the common area with other residents and with staff and visitor walking by. Resident #184's urinary drainage bag was hanging on the side of his reclining wheelchair uncovered with urine visible. An observation of Resident #184 was conducted 11/1/2021 at 3:47 pm. Resident #184 was sitting in his reclining wheelchair in the common area and his urinary drainage bag was hanging from the side of his wheelchair and was not covered with urine visible. On 11/3/2021 at 3:45 pm Resident #184 was observed in his reclining wheelchair in the hallway. Resident #184's urinary catheter bag was hanging on the side of the reclining wheelchair without a cover on the bag with urine visible. The Director of Nursing was interviewed on 11/4/2021 at 1:32 pm and stated a privacy bag should have been in place for any resident that has a urinary catheter bag. The Director of Nursing stated the Nurse would be responsible for ensuring the privacy cover was in place over the urinary drainage bag since there was a physician's order. On 11/4/2021 at 1:37 pm the Administrator was interviewed and stated the dignity of all residents should be maintained. She also stated privacy covers are something the facility does to maintain	F 550	months. The audits will be conducted by the Director of Nursing/designee. Auditing will begin during the week of November 22, 2021. Results of the audits will be taken to the Quality Improvement Committee for review and further recommendations.	

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F 550	Continued From page 3 the resident's dignity.	F 550		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		12/6/21

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F 584	Continued From page 4 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and safe environment by failure to maintain drywall on the walls without holes or scratches into the drywall for three of four resident rooms/bathroom (room 204-bathroom, room 208, and room 814) reviewed for environment. Findings included: 1a. Observations of the bathroom between rooms 202 and 204 conducted on 11/1/21 at 12:07 PM and 11/3/21 at 9:03 AM revealed the cove base to be loose for the half wall between the tub and the toilet. Further observation revealed holes in the drywall behind the loose cove base. 1b. Observations of the drywall to the left of and under the sink in room 208 conducted on 11/1/21 at 4:05 PM and 11/3/21 at 8:59 AM revealed two holes. Closer inspection revealed the holes to have been partially occluded by loose cove base. One of the holes appeared to be about the size of a softball and the second was about the size of a baseball. An interview and observation were conducted on 11/4/21 at 8:14 AM with the Maintenance Assistant. She stated she wasn ' t aware of the hole in the drywall of the bathroom between rooms 202 and 204 nor was she aware of the	F 584	*The bathroom half wall in between rooms 202 and 204 was repaired to include the holes in the drywall and loose cove base. The area under the sink with the holes in the wall in room 208 was repaired. The wall with visible damage to the drywall exposing the sheet rock was repaired in room 814. These repairs were done between November 9 - 19, 2021 by the Maintenance Director. *The Administrator conducted an audit throughout the facility on November 9, 2021 to identify other wall/cove base integrity issues. A list was made of rooms in need of wall or cove base repairs and the Maintenance Director will ensure the proper repairs are done. This repair work is in progress and will be completed by December 6, 2021. *The Maintenance Director and Maintenance Assistant were reeducated by the Administrator on the residents' right to have a safe, clean, comfortable and homelike environment. This was completed on November 22, 2021. All staff were reeducated on our work order system so that repairs to walls and cove base can be done timely. This education was completed by the Administrator, Certified Dietary Manager and the Staff Development Coordinator during November 8 – 19, 2021.	

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F 584	Continued From page 5 loose cove base where there was drywall damage. She further stated the holes in the drywall near the sink room 208, which were partially covered by loose cove base were about the size of a softball for one and a baseball for the other. She said she expected for staff members, nursing, or housekeeping, whenever they saw damage to the drywall, or loose cove base, to complete a work order. She said she had not received a work order for the damaged drywall or the loose cove base. An interview and observation were conducted on 11/4/21 at 9:10 AM with Nursing Assistant (NA) #7. She observed the hole in the drywall of the bathroom between rooms 202 and 204 and the loose cove base where there was drywall damage. She further stated the holes in the drywall near the sink room 208, which were partially covered by loose cove base were about the size of a softball for one and a baseball for the other. She said she had written work orders for things like bed controls but had not and would not write a work order damage to drywall or cove base. She said she believed mostly housekeeping would write work orders for wall damage like that. An interview and observation were conducted on 11/4/21 at 9:15 AM with Housekeeper (HSK) #1. She observed the hole in the drywall of the bathroom between rooms 202 and 204 and the loose cove base where there was drywall damage and she had said she wrote a work order to have the area repaired "last week." She further stated the holes in the drywall near the sink room 208, which were partially covered by loose cove base were about the size of a softball for one and a baseball for the other, she was aware of and had	F 584	*Audits of walls and cove base will be done in five random rooms by the Administrator/designee. This will be done weekly for three weeks and monthly for three months. Administrator will also audit three work orders at random per week for three weeks and then monthly for three months to ensure timely completion of the request. Auditing will begin the week of November 22, 2021. Results of these audits will be taken to the Quality Improvement Committee for further recommendations.	

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F 584	Continued From page 6	F 584		

written a work order "a day or two ago."

During an interview and observation conducted on 11/4/21 wat 11:54 AM with the Director of Nursing (DON) she stated she expected her nursing staff to write a work order for damage to the drywall such as what was observed in the bathroom in between rooms 202 and 204 and near the sink in room 208.

The Administrator stated, during an interview conducted on 11/4/21 at 2:51 PM, matters which would be out of compliance, such as damaged drywall, needed to be reported as a work order, and then it would need to be addressed by maintenance.

2. An observation on 11/3/21 at 8:08 AM of Room 814 was completed. One resident occupied room #814 revealed the wall had visible damage to the drywall exposing the sheet rock.

Observations were conducted during a round with the Assistant Maintenance Director on 11/4/21 at 8:31 AM who stated the damaged drywall was due to the bed which had been formerly in place, being lowered and raised causing gouges in the wall. The Assistant Maintence Director stated it appeared the damaged drywall was approximately 2 ½ feet wide. The Assistant Maintenance Director was asked how the Maintenance department would become aware of damaged walls and she stated that any staff that sees an area that needs repair can fill out a work order which is kept in a manilla folder at the nurse's station. An observation with the Assistant Maintenance Director of the manilla folder was completed at the nurse's station. The Maintence request form included the work order date, the department requesting the service, location of

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F 584	Continued From page 7 repairs and the name of the person making the request and the type of repair needed. The Assistant Maintenance Director stated that she will check the manilla folder daily, however some staff will just come and report it to her, and it is fixed immediately. An interview was completed with Nursing Assistant #3 on 11/4/21 at 11:14 AM who stated at the nurse's station is a request form for needed repairs. NA #3 stated that she had been talking about the holes in room 814 with another staff member but did not fill out a request form. NA #3 stated that all the Nurses and the Nursing Assistants are aware of the conditions of all rooms. NA #3 stated that she had sometimes mentioned needed repairs to a nurse and sometimes will fill out a request form. On 11/4/21 at 2:13 PM an observation of room #814 was completed with the Administrator who stated that if there is a hole found in the wall a work order should be done and the Maintenance follows the work order system, and it should be repaired. The Administrator stated that anyone can fill out a work order.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical	F 637		12/6/21

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F 637	Continued From page 8 interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to identify and complete a significant change in condition assessment after the resident was admitted to hospice services for 1 of 2 residents reviewed for hospice services, Resident #80. Findings included: Resident #80 was admitted to the facility on 8/5/2021 and died in in the facility on 9/27/2021. Her diagnoses included dementia and diabetes. An admission Minimum Data Set (MDS) assessment dated 8/12/2021 revealed Resident #80 was not receiving hospice services. A Physician's Order for Hospice Services was dated 8/26/2021. A Hospice Care Plan dated 8/26/2021 stated Resident #80 was admitted to hospice services for a diagnosis of dementia. Review of Resident #80's MDS assessments revealed there was not a significant change MDS assessment completed after Resident #80 was admitted to hospice services. During an interview with the Minimum Data Set (MDS) Coordinator on 11/4/2021 at 3:07 pm she stated Resident #80 was admitted to hospice services on 8/26/2021 but a significant change	F 637	*Resident #80 expired in the facility September 27, 2021 therefore a significant change assessment cannot be completed. *The Director of Nursing completed a 30 day lookback of residents who were admitted to hospice services to determine whether the facility completed a significant change assessment. Of the residents identified to qualify for a significant change assessment, all had an assessment completed according to the RAI manual guidelines. *The two MDS nurses were reeducated by the Administrator on November 9, 2021 on the RAI manual definition/instructions on significant change assessments. *The Administrator/designee is conducting a daily audit to ensure residents who qualify for a significant change assessment have one initiated by an MDS nurse. This audit will be completed Monday through Friday (Monday we will capture activity from Saturday and Sunday) via the 24 hour reporting process/Interdisciplinary Team meeting. This auditing was initiated on November 9, 2021 and will be conducted on an ongoing weekly basis weekly for three weeks. Thereafter, the audits will be conducted monthly for three months. Results of this auditing will be reviewed with the Quality Improvement Committee	

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F 637	Continued From page 9 assessment was not completed. She stated a significant change assessment should be completed for any resident admitting to or discharging from hospice services. An interview was conducted with the Administrator on 11/4/2021 at 3:35 pm and she stated she did not know why a significant change assessment was not completed for Resident #80. She also stated the facility conducts a daily clinical meeting and all new resident orders are checked daily. The Administrator stated the MDS Coordinator attends the clinical meeting and should have been aware of Resident #80's admission to hospice services.	F 637	for further recommendations.	
F 677 SS=E	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 observation, record review and staff interviews the facility failed to provide personal care for 2 of 3 residents, Resident #1 and Resident #28. Resident #1 was not provided thorough incontinence care and #28 was observed with dark matter under her nails. Findings included: 1. Resident #1 admitted to the facility on 5/7/2021 with diagnoses of lung disease, kidney disease and brain injury. A Quarterly Minimum Data Set assessment dated	F 677	*Resident #1 had his penis foreskin retracted and cleaned according to policy on November 4, 2021 by the Staff Development Coordinator. Resident #28 had her nails trimmed and had the dark matter removed by a nursing assistant on November 4, 2021. *The Director of Nursing audited all male residents in the facility to determine who was uncircumcised. During this audit process, any corrections needed related to cleanliness were made by the Director of Nursing. This audit was conducted on November 11, 2021. An audit was	12/6/21

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F 677	Continued From page 10 7/22/2021 revealed Resident #1 was moderately cognitively impaired and required extensive assistance with personal hygiene. The assessment further revealed Resident #1 was always incontinent of bladder and bowel. Resident #1's Care Plan dated 6/17/2021 stated he was at risk for poor hygiene due to deconditioning and impaired mobility. The Care Plan further stated Resident #1 required assistance with all activities of daily living including toileting and personal hygiene. During an interview with Nurse Aide #2 she stated Resident #1 required total assistance with all activities of daily living including bathing and incontinence care. An observation of Resident #1's incontinence care was completed with Nurse Aide #3 on 11/4/2021 at 10:25 am. Nurse Aide #3 did not retract Resident #1's foreskin to ensure his penis was clean during the observed incontinence care. An interview was conducted with Nurse Aide #3 on 11/4/2021 at 10:57 am. Nurse Aide #3 stated she was taught about incontinence care when she was attending Nurse Aide class but she had not done incontinence care for a male resident in the class. Nurse Aide #3 stated the facility had done training on incontinence care when she was hired but no one had observed her preforming incontinence care during her orientation. During an interview with the Staff Development Coordinator (SDC) on 11/4/2021 at 11:51 am she stated when a Nurse Aide is hired a skills checklist is completed with them during orientation and then they have an annual skills	F 677	performed by the Administrator on November 22, 2021 of all resident's fingernails. A list was created by the Administrator of residents needing cleaning of the nails, a trimming of nails or both. These residents in need of additional nail care will have the care completed November 24, 2021. Residents who wish to keep their nails at a longer length will have their plans of care updated by the Director of Nursing/designee by November 22, 2021. *Nursing assistants were reeducated and had a competency completed for perineal care completed by November 23, 2021. They showed competency to the Staff Development Coordinator. They were also reeducated on the Indwelling Urinary Catheter Care Procedure by the Staff Development Coordinator by November 23, 2021. The nursing assistants were also reeducated on our morning care policy to include the need to complete nail care. This was completed November 23, 2021. *The Staff Development Coordinator/designee will conduct five observations per week of nursing assistants completing perineal care. This will occur weekly for three weeks and then monthly for three months. Auditing will begin during the week of November 22, 2021. The Administrator/designee will audit five random residents a week for nail length and proper sanitation. The audits will be initiated during the week of November 29, 2021 and will continue weekly for three weeks. Then the audits will be done by the Administrator monthly	

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F 677	Continued From page 11	F 677		

review. The SDC stated the skills checklist outlines every skill and expectation. The SDC also stated the skills are discussed but she does not necessarily see them do incontinence care. She stated there would not be enough time for her to see every nursing staff member return demonstrations of the skills on the skills checklist. The SDC stated there was information on the skills checklist for incontinence care for the Nurse Aide's to pull back the foreskin if a male resident is not circumcised. The SDC stated she thought Nurse Aide #3 was scared and stressed during the observation and it caused her to forget to pull back the foreskin.

On 11/4/2021 at 12:35 pm the SDC provided a copy of Nurse Aide #3's skills checklist from her orientation and it showed the incontinence care for a male resident was demonstrated on 5/28/2021 and her proficiency was verified in the facilities lab and she also performed the skill on 6/3/2021.

During an interview with the Director of Nursing on 11/4/2021 at 1:28 pm she stated Nurse Aide #3 should have pulled back the foreskin and cleaned Resident #1's penis during incontinence care. She stated the facility does a skills checklist on all Nurse Aides during orientation and annually.

An interview was conducted with the Administrator on 11/4/2021 at 1:40 pm and she stated she is not a clinician and would not know what competencies Nurse Aide #3 had during orientation. The Administrator stated the Nurse Aides should be educated during their Nurse Aide training and general competency and education should be completed by the facility to ensure

for three months. Results of the audits will be taken to the Quality Improvement Committee for review and further recommendations.

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F 677	Continued From page 12 Nurse Aide skills are done properly.	F 677		

2. Resident #28 was admitted to the facility on 5/15/19. The resident ' s cumulative diagnoses included Aphasia (being unable to speak), stroke, hemiplegia (paralysis of one side of the body), and generalized weakness.

Resident #28 ' s most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/3/21. The resident was coded as having severe cognitive loss. The resident was also coded as having required extensive assistance of one to two people for all Activities of Daily Living (ADLs) including dressing, toilet use, personal hygiene, and bathing.

Resident #28 ' s care plan, which was most recently reviewed on 9/15/21, revealed the resident had a Focus area of being at risk for self-care deficits/poor hygiene due to muscle weakness and deconditioning related to stroke with right sided hemiplegia. The goal was for the resident ' s need to be met with the assistance from staff. There was an intervention listed to provide needed assistance with self-care daily and as needed.

Observations of Resident #28 ' s fingers conducted on 11/1/21 at 12:49 PM and 11/2/21 at 1:37 PM revealed five of five fingernails on the resident ' s left hand, had dark debris under the free edge of each nail. Due to having had

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paralysis of the right side of the body from a stroke, the resident utilized her left hand for all activities which would have utilize her hands. Further observation revealed the resident ' s free edge of each fingernail extended beyond the end of the resident ' s fingers on ten of ten of her fingers.

An observation of Resident #28 ' s fingers was conducted in conjunction with an interview with Nursing Assistant (NA) #8 on 11/3/21 at 8:25 AM. The NA was feeding the resident breakfast at the time of the observation. The observation revealed five of five fingernails on the resident ' s left hand, had dark debris under the free edge of each nail and the free edge of each fingernail extended beyond the end of the resident ' s fingers on ten of ten of her fingers. The NA stated the resident was on her assignment. She said the resident could use her left hand for activities such as using her phone and she pointed to a smart phone which was near the resident ' s left hand. She further stated it did appear the resident ' s nails needed to be trimmed because of the nails being long and cleaned because of the dark matter under the nail bed on the resident ' s left hand.

An observation of Resident #28 ' s fingers conducted on 11/4/21 at 8:55 AM revealed five of five fingernails on the resident ' s left hand, had dark debris under the free edge of each nail. Further observation revealed the resident ' s free edge of each fingernail extended beyond the end of the resident ' s fingers on five of five fingers on the right hand.

An interview and observation were conducted during a round on 11/4/21 at 11:54 AM with the

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F 677	Continued From page 14 Director of Nursing (DON). Resident #28 was observed to have had dark matter under five of five nails on her left hand. The DON stated the resident may have acquired the dark matter under the nails on her left hand in between the time when the NA had trimmed her nails yesterday and the observation today. The DON stated it was the responsibility of the NAs to provide nail care and the dark matter needed to be cleaned out from nails on the resident ' s left hand and if the nails on the resident ' s left hand needed to be trimmed, they would be trimmed. During an interview conducted with the Administrator on 11/4/2 at 2:51 PM she stated nail care, such as cleaning and trimming nails, needed to be completed as part of routine ADL care and when a resident received a shower was also a good opportunity to provide nail care.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		12/6/21

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F 761	Continued From page 15 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure there were no expired medication in 1 of 2 medication rooms (200, 400, 600, 800 halls medication room). Findings included: On 11/3/21 at 10:26 AM a review of the 200, 400 and 600 hall medication storage room was completed with Nurse #5. It was noted that 1 vial of the medication Cyanocobalamin Solution 1000 micrograms/milliliter(mcg/ml) was in the medication refrigerator in a sealed plastic ziplocked bag for Resident #54. The vial of Cyanocobalamin solution 1000 mcg/ml vial was noted to have expiration date printed on the label of 07/2021. A review of the physician orders for Resident #54 indicated that the medication was ordered on 07/15/20 and discontinued on 07/29/20. An interview with Nurse #5 was conducted on 11/03/21 at 10:30 AM. She stated the medication Cyanocobalamin should have been checked for the expiration date when checking medications and should have been sent back to pharmacy for credit for the resident if had been	F 761	*The LPN house supervisor, on November 3, 2021, properly disposed of the expired vial of the Cyanocobalamin Solution 1000 micrograms after the surveyor identified it. *On November 9, 2021 the Director of Nursing conducted an audit of both the medication fridge for halls 200, 400, 600 and 800 as well as the medication fridge for halls 100 and 300 and did not find any additional expired medication *The license nursing staff were reeducated on the policy for storage and expiration of medication, biological, syringes and needles by the Staff Development Coordinator by November 19, 2021. Included in this education were the expectations of removing discontinued medications from the refrigerator and sending back to pharmacy. *The Director of Nursing/designee will audit the medication room refrigerators for hallways 200, 400, 600 and 800 as well as the 100 and 300 halls to ensure no expired medications are present. This auditing was initiated November 22, 2021. It will be conducted weekly for three weekly then monthly for three months.	

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F 761	Continued From page 16 discontinued. The Director of Nursing was interviewed on 11/03/21 at 04:48 PM regarding the expired medication in the refrigerator in the Medication Room for the 200, 400, 600 and 800 halls. She stated the medications that were stored in the refrigerator should be only for the active and current orders. She noted expired medications or medications that were about to expire should be pulled out of circulation from the medication areas. An interview was done with the Administrator on 11/03/21 at 02:56 PM regarding the expired medication in the medication refrigerator. She stated there should not be expired medications in the facility.	F 761	Results of this auditing will be reviewed with the Quality Improvement committee for further recommendations.	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with residents (Resident #38, #26) a resident council meeting, staff interviews and a test tray the facility failed to provide food that was at an appetizing temperature for 2 of 17 residents reviewed for food palatability.	F 804	*Administrator met with Resident #26 and Resident #38 to discuss the palatability of the meals and to review their expectations on food palatability. A grievance form was generated for each resident to reflect their concerns expressed. This was done on	12/6/21

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F 804	Continued From page 17 The findings included: a. Resident #38 was admitted to the facility on 3/29/21. The quarterly minimum data set dated 9/29/21 revealed Resident #38 was cognitively intact. During an interview on 11/1/21 at 12:23 PM, Resident #38 stated the food was always cold, especially breakfast. A follow up interview was completed with Resident #38 on 11/4/21 at 11:00 AM who stated the food was cold all the time especially the vegetables, the mashed potatoes and breakfast. "And we have voiced our concerns about it". Resident #38 stated the food was cold at breakfast on 11/3/21 as well as the breakfast today. b. Resident #26 was admitted to the facility on 10/3/2014. The significant change minimum data set dated 8/21/21 revealed Resident #26 was cognitively intact. During an interview on 11/1/21 at 3:36 PM, Resident #26 stated when the food carts come to the floor, he had observed the trays sitting on the carts for a while before it gets delivered. "A lot of residents have complained about this". Resident #26 was also the Resident Council President. c. During a resident council meeting with 17 residents on 11/2/21 at 2:24 PM residents expressed that food was cold. One resident stated the breakfast food was cold if it is coming from the carts. The resident stated the trays sit on the food carts and the Nursing Assistants (NA) don't get the trays passed out on time. The resident stated you only get hot food if you go to the dining room.	F 804	November 23, 2021. *On November 17, 2021 the Certified Dietary Manager held the monthly Food Committee to discuss food temps and palatability with the group and to review their expectations of meal service. *The Certified Dietary Manager was reeducated by the Food Service Consultant on November 10, 2021 on the residents' right to receive meals that are palatable and at the proper temperature. The dietary staff were reeducated by the Certified Dietary Manager that it is their responsibility to deliver the meal service tray carts to the nursing units. Also they were reeducated on the residents' right to receive meals that are palatable and at the proper temperature. This reeducation was completed on November 15, 2021. The nursing staff was educated by the Staff Development Coordinator on November the 19, 2021 on the expectation residents receive food that is palatable and that trays must be passed timely when they arrive on the units. *The Administrator/designee will conduct random auditing of five residents a week to ensure the meals are palatable to him/her and at an acceptable temperature. This will occur weekly for three weeks then monthly for three months. Also the Administrator/designee will audit the time that it takes from tray truck arrival on the units to the time the trays begin to be delivered to the residents. This auditing also will begin the week of November 22, 2021; weekly for three weeks then monthly for three months. Lastly, once a week the	

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F 804	Continued From page 18 On 11/3/21 at 7:50 AM Cart #2 was transported to the 800 hallway, Cart #1 for the 800 hallway was on the hall awaiting tray delivery to the residents. A continued observation with the Dietary Manager (DM) on the 800 hall began at 7:50 AM. At 7:58 AM the trays were observed sitting on the carts, and the DM stated that he would come back when the trays were being passed. At 8:08 AM to 8:13 AM the food trays were being delivered to the residents on the 800 hall. The DM retrieved the test tray which was the last tray from cart #2 at 8:13 AM and the tray was taken to the dining room. At 8:15 AM a test tray evaluation was conducted with the Dietary Manager. The food items were on a plate which was on an unheated round bottom base with a dome plastic cover. There was no steam coming from the food items when the tray had been uncovered. The food items consisted of scrambled eggs, bacon, toast, and grits (which was in an insulated bowl), coffee was in an insulated cup and orange juice. Both the DM and Surveyor felt the toast which was not hot when touched and agreed it was more like room temperature. The Surveyor tasted the eggs which were barely warm, the grits and coffee were hot and the bacon was cold. The Dietary Manager did not taste the food. An interview was completed with the DM on 11/4/21 at 1:57 PM The DM stated that on 11/3/21 when the test tray evaluation was completed there had been about 20 to 25 minutes before the trays were delivered. The DM stated that occasionally he had been aware of food complaints related to temperature. The DM stated with all the trays that need to be passed it may take that long to get things passed out.	F 804	Administrator/designee will conduct a test tray audit during a random meal to determine whether the food is at proper temperature and palatable in nature. This will occur weekly for three weeks then monthly for three months to begin the week of November 22, 2021. Results of this auditing will be reviewed with the Quality Improvement Committee for further recommendations.	

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F 804	Continued From page 19 An interview was completed with the Administrator on 11/4/21 at 2:11 PM and she stated that it would be her expectation that the residents have food that is desirable and palatable to them.	F 804		
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 reviews, staff interviews and observations the facility failed to clean 1 of 1 oven vent, failed to label and refrigerate an opened nutrition supplement in use for 1 of 3 nourishment/medication rooms (Medication Room on the 200, 400, 600 and 800 halls) reviewed, and failed to remove expired food items stored for use in 1 of 1 reach-in refrigerator observed. These practices had the potential to	F 812	*The oven vent was cleaned by a dietary aide at the time the surveyor identified the brown fuzzy matter on November 2, 2021. The two cited supplements as well as the thickened cranberry juice was discarded by the Certified Dietary Manager on November 1 and November 3, 2021. *The Certified Dietary Manager audited all other areas of the kitchen to ensure	12/6/21

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F 812	Continued From page 20 affect the food served to residents. Findings included: 1. A tour of the kitchen was conducted on 11/01/21 at 09:55 AM with Dietary Aide #1. The Dietary Manager was not available. A tour of the cooking area and food preparation area on 11/01/21 at 10:27 AM revealed the slats in the grate above the stove were covered with dark brown fuzzy matter that was protruding downward. An interview was conducted with Dietary Aide #1 regarding the vent on 11/01/21 at 10:30 AM and she stated an outside vendor came to clean the grates and "it looks like it needed cleaned again." The Dietary Manager was interviewed again on 11/03/21 at 10:20 AM and stated he had one of his staff clean the vents above the stove. He stated an outside vendor was contracted to clean the vents twice a year and were there in September 2021. He said staff cleaned the vents when they were dirty in between the 2 visits. He stated he observed the vents and recorded the status on a monthly sanitation report. A review of the 10/26/21 Monthly Sanitation Audit documented "the vents/hood-grease build up" as 'No" and it was signed by the Dietary Manager. The Dietary Manager was interviewed on 11/04/21 at 02:02 PM regarding the oven grid and stated it should have been cleaned between servicing. 2. The refrigerator in the Medication Room on	F 812	proper sanitation on November 5, 2021 and no other concerns were noted. The Certified Dietary Manager audited the kitchen refrigerators, freezers and nourishment rooms and no other expired or undated supplements or liquids were found. *The Certified Dietary Manager was reeducated on food storage expectations/policies, labeling and dating food/liquids, ensuring proper kitchen sanitation and ensuring proper dating/discarding of thickened liquids and supplements. This occurred on November 10, 2021. The dietary staff were reeducated by the Certified Dietary Manager on November 8 – 15, 2021 on food storage expectations/policies, labeling and dating food/liquids, ensuring proper kitchen sanitation and ensuring proper dating/discarding of thickened liquids and supplements. The nursing staff were reeducated on ensuring proper dating/labeling of opened supplements and thickened liquids during November 10 – 19, 2021. This reeducation was done by the Staff Development Coordinator. *Audits of the sanitation in the kitchen to include the oven vent will be conducted by the Administrator/designee weekly for three weeks then monthly for three months. Audits of the nourishment rooms, medication carts, kitchen refrigerators and freezers will also be done by the Administrator/designee to ensure thickened liquids and supplements are properly dated and discarded according to each expiration date. These audits will be done weekly for three weeks	

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F 812	Continued From page 21 the 200, 400, 600 and 800 halls was checked with Nurse #5 on 11/03/21 at 10:26 AM. A vanilla flavored nutritional supplement was opened on the medication cart that was stored in the room without a date. Instructions on the side of the container were to consume within 4 hours if not refrigerated. The medication cart had been utilized by Nurse #1 on 11/03/21. Nurse #1 was interviewed on 11/03/21 at 02:34 PM and stated she had opened the carton at approximately 07:30 AM on 11/03/21 and forgot to place it in the refrigerator when she completed her medications. On 11/03/21 at 03:36 PM the Nourishment room refrigerator for the 100 and 300 halls, was checked with Nurse #4. A 32 oz container of a nutritional supplement was dated as opened on 10/28/21. The container was ¾ empty. The recommendation on the container was to discard within 4 days of opening. The Dietary Manager was interviewed on 11/04/21 at 02:02 PM regarding the 2 nutritional supplements that had identified concerns, one without a date when it was opened and not placed in the refrigerator for over 4 hours and the other opened nutritional supplement with an expired date of 10/25/21 in the nourishment refrigerator. The dietary manager stated the nutritional supplements should have been dated when opened, refrigerated and discarded per the manufacture recommendations. 3. Inspection of the refrigerator on 11/01/21 at 10:17 AM with Dietary Aide #1 revealed an opened 32 ounce bottle of thickened cranberry juice with the date written 10/10/21.	F 812	and monthly for three months. Results will be taken to the Quality Improvement Committee for review and further recommendations.	

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F 812	Continued From page 22	F 812		

An interview with Dietary Aide #1 was conducted on 11/01/21 at 10:20 AM regarding the opened container of thickened cranberry juice and she noted that she thought it was still good. She noted she was not sure how long it could be opened and kept refrigerated and she was not familiar with the labelling protocol.

An interview was done with the Kitchen Manager on 11/02/21 at 03:50 PM regarding labelling of the juice. He stated he had a facility guideline for food and how long the items could be stored. He said the cranberry juice should have been discarded at 7 days.

The Director of Nursing was interviewed on 11/03/21 at 04:48 PM regarding the unmarked and expired nutritional supplements. She stated the staff should follow the manufacture guidelines for the nutritional supplements and date when it is opened, refrigerate within the timeframe listed and dispose of it when outdated.

The Administrator was interviewed on 11/03/21 at 2:48 PM regarding food labelling in the kitchen and nourishment rooms. She stated she would expect these items would be labelled, refrigerated and discarded per the dietary and manufacture guidelines and staff should be aware of proper food sanitation according to the policy. The Administrator was asked about the kitchen vents near the stove and said these should be clean and sanitary.