STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345576	A. BUILDING _____ B. WING _____	C 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HEALTH & REHAB CENTER	1716 LEGION ROAD CHAPEL HILL, NC 27517

(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 survey was conducted on 4/4/22 through 4/8/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 357R11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 4/4/22 through 4/8/22. Intakes NC00180697, NC00185286, NC00185894, NC00186417, and NC00187026 were investigated. 4 of the 15 complaint allegations were substantiated. Event ID # 357R11.	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	F 550		5/21/22

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

Electronically Signed | 05/02/2022

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §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 record review, resident and staff interviews the facility failed to provide a dignified experience for Resident #149 who indicated she waited over 3 hours for her call bell to be answered and this made her feel ignored and bad. This was evident for 1 of 5 residents reviewed for dignity. Finding included: Resident #149 was admitted to the facility on 03/31/2022 with current diagnoses of joint replacement surgery and hypertension. Resident #149 ' s admission minimum data set (MDS) assessment had not been completed yet, however Resident #149 was able to make her needs known to staff.	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550 The facility failed to treat residents in a dignified manner by not responding to call lights in a timely manner. 1. Corrective action for resident(s) affected by the alleged deficient practice:	

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F 550	Continued From page 2 During an interview with Resident #149 on 04/05/2022 at 11:30 am revealed her first night at the facility was horrible. Resident #149 indicated she and her roommate got hot and the call bell was put on around 8:00 PM for help with the room temperature and for assistance going to the bathroom. She stated the physician did not want her to try and go to the bathroom by herself. Resident #149 indicated she waited so long she texted a friend around 10:30 pm and her friend called the facility to get her some help. She added a male staff member came to the room around 11:00 PM. Resident #149 indicated during the time he was present in the room she went to the bathroom and got back in bed. Resident #149 stated the male staff members behavior made her feel bad and vulnerable. Resident #149 added she was a ' little afraid of the staff ' s behavior". Resident #149 was thankful for the outside help she received from her friend. Resident #149 indicated this information was reported to someone at the facility the next day, but she couldn ' t remember the name of the staff member she told because she was so new to the facility Review of the grievance log on 04/05/2022 revealed no grievance from Resident #149, however on 04/06/2022 the Administrator provided a grievance from Resident #149 and stated it had been placed under another resident ' s name. An interview was conducted with the Social Worker (SW) on 04/07/2022 at 11:35 am. She indicated she was aware of the incident and stated she had to get the information from the Administrator. SW also indicated that Resident	F 550	On 4/4/2022 resident #149 was assessed/interviewed by the DON/Administrator for any care related concerns. Results: No further care related concerns and no identified change in condition noted. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 4/26/2022 thru 05/02/2022, the Director of Nurses/Administrator/Social Worker audited call light response time by direct observation on all hallways for 100% of residents on all shifts with no other delay in call light response times observed. On 4/29/2022 the administrator reviewed the last 14 days of grievances and Resident Council minutes for the month of April for identified concerns with call bell response time. Results: No concerns identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/27/22, the Director of Nurses and Nurse Consultant began education of all full time, part time, as needed, agency nurses and CNA’s and department managers on facility policy on assuring that residents are rounded on at least every two hours and that call lights are answered timely, with good customer service, along with applicable resident rights related to maintaining resident dignity. Education will be completed by 5/20/22 at which time all of the above	

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F 550	Continued From page 3 #149 was able to communicate her needs and wants. Review of the grievance revealed the investigation was still being completed by the Administrator. The male staff member who worked with the resident was contacted and no returned call was received. An interview with Nurse Aide #2 on 04/07/22 at 10:30 PM, indicated she worked on 03/31/22, but she was not assigned to Resident #149. She indicated she had no knowledge of any call bell being on for 3 hours or longer. Nurse Aide #2 indicated they answered all the call lights whether they were their assigned resident or not. During an interview with Nurse #2 on 04/08/2022 at 11:52 AM, Nurse #2 indicated he was the Nurse on the hall on 03/31/2022. He indicated after completing the medication pass, he was at the nurse ' s station and received a call from someone outside of the facility that Resident #149 needed help to the bathroom and had waited a long time. Nurse #2 indicated he went to the room and assisted Resident #149 to the bathroom. He stated he was not aware of where the residents Nurse Aide was at that time and was not sure how long the call light had been on Interview with the Director of Nursing (DON) on 04/08/22 at 12:30 PM revealed he expected the staff to treatment residents with respect and dignity. Interview with the Administrator on 04/08/22 at 1:00 PM revealed it was her expectation all	F 550	must be in-serviced prior to working. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or Designee will monitor compliance utilizing the F550 Resident Rights Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occur on various shifts and days of the week to include weekends to assure that residents are being rounded on at least every two hours by staff and that their dignity is being maintained as it pertains to timely response to call lights by staff for resident assistance. The Administrator/Director of Nurses/Social Worker will monitor that residents are being treated in a dignified manner by auditing resident satisfaction with call bell response time weekly x 2 and monthly x 3. This will include auditing 4 alert residents on various halls and contacting 3 Responsible Parties for those residents with a Brief Interview for Mental Status below 13. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager.	

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F 550	Continued From page 4 residents were treated with respect and dignity. The Administrator stated when she spoke with Resident #149, she did not say anything about her wait time only that the Nurse was unprofessional.	F 550	Date of Compliance: 5/21/2022	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews, the facility failed to assess a resident to determine if self-administration of medication was clinically appropriate. Resident #85 was observed to have medications in her hand and at bedside. This was evident during one of one observation of Resident #85. Finding included: Resident #85 was admitted to the facility on 02/17/22 and diagnoses included chronic heart failure, presence of cardiac pacemaker and anemia. Review of Resident #85 ' s admission Minimum Data set (MDS) indicated her cognition was moderately impaired and she needed extensive one-person assist with her activities of daily living, however she could feed herself with set up help only. During an observation on 04/05/22 at 10:33 AM in Resident #85 was observed in her room holding a	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated F 554 The facility failed to assess whether the self-administration of medications was clinically appropriate for resident # 85 who had meds at bedside. 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident #85 the medication was removed from bedside on 4/05/2022 by the assigned nurse and the resident was educated on the need for the nurse to administer all medications and observe	5/21/22

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F 554	Continued From page 5 medication cup of pills. The medication cup included 2 pink pills, one yellow pill, one white pill and one clear capsule. There were 2 tubes of zinc oxide ointment on the bedside table. During an interview with Resident #85 on 04/05/2022 at 10:40 AM Resident #85 indicated the nurses always left her medications with her because it took her a long time to take them. She indicated the nurses would tell her to take them all and she would respond "Lord I got so many ". Nurse #1 entered Resident #85 ' s room at 10:55 PM on 04/05/22 and indicated she had stepped out of the room to get the resident ' s inhaler. Nurse #1 stated Resident #85 had not been assessed for self-administration of her medication. Nurse #1 indicated she was not sure of the time that she gave Resident #85 her medication, but it was sometime after 10:00 am and it was her 9:00am scheduled medications. Nurse #1 indicated Resident #85 had not been assessed for self-administration. Review of Resident #85 ' s medical record did not reveal a physician ' s order for self-administration of medications. During an interview with the Administrator on 04/08/22 at 1:06 PM she stated it was her expectation for nurses to complete their medication pass and stay in the room with residents to ensure they took their medications.	F 554	that they have been taken by the resident. Assessment by the nursing team did not indicate that the resident was a candidate for self-administration of her medications. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 4/27/2022 the Director of Nurses audited all resident rooms to assure that no medications were found at bedside that had not been assessed for resident self -administration with no other concerns identified and there were no other residents who were requesting to self-administer medications or to keep meds at bedside. No other medications were found at bedside. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 4/27/2022 the Director of Nurses and Nurse Consultant began education of all Full Time, Part Time, PRN and agency nurses on facility policy related to medication safety that included resident assessment for self -administration of medication process and safely securing and storing medications. Education will be completed by 5/20/2022. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The facility specific in-service will be provided to all agency Nurses and CNA’s who give residents care in the facility.	

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F 554	Continued From page 6	F 554	Any nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by May 20, 2022. 4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Quality assurance audits will be completed by the Director of Nurses or designee to assess that the medication self- administration process is in compliance and that no other meds are at bedside if the resident is not appropriate for self-administration. Audits of 6 resident rooms will be completed on various days of the week and shifts to assure compliance with the medication storage policy. Audits will be done weekly for 2 weeks, then monthly for 3 months or until resolved for compliance with facility policy on self- administration of medication process. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, acting Residential Care Coordinator, Activity Director and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility	

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F 554	Continued From page 7	F 554	Quality Assurance process. Date of Compliance: 5/21/2022	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide a written order for treatment to open skin wounds to bilateral posterior legs for 1 of 2 residents (Resident #248) reviewed for wound care. Resident # 248 was admitted to the facility on 3/28/22 and had a history of calcific tendinitis of left shoulder, hypertension, anemia, obstructive sleep apnea, morbid obesity, lymphedema, and gastro-esophageal reflux disease. Admission minimum data set was not completed, however a review of Resident #248 ' s progress notes indicated her cognition was intact. A review of admission assessment dated 3/28/22 read in part skin turgor good, normal skin care required, including diabetic skin assessment, dry skin, bruises, abrasions. A review of weekly skin assessment dated 3/28/22 revealed existing skin conditions as follows: "skin tear, resident has excoriated areas to lower back, left buttock, skin tear to rt inner	F 658	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F658 The facility failed to provide a written order for treatment to open skin wounds to bilateral posterior legs for Resident # 248. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 04/07/2022 the Director of Nurses verified that a treatment order was obtained and had been administered to resident # 248 as ordered by the physician. 2. Corrective action for residents with	5/21/22

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F 658	Continued From page 8 lower leg". A care plan dated 4/1/22 revealed Resident #248 was at risk for pressure ulcer development due to decreased ability to assist with repositioning. Goal was to minimize risk for development of pressure ulcers through the interventions that were in place. Interventions included the use of devices to aid with positioning in bed to reduce friction/shearing. A review of the treatment record (TAR) for the month of April 2022 revealed treatment to cleanse sacral wounds with normal saline, pat dry, apply thick calazime barrier cream every other day. No order was noted for areas to lower back, left buttock, or rt inner lower leg. An interview was conducted on 4/5/22 at 12:18 pm and it was indicated Nursing Assistants (NA ' s) were instructed to provide wound care by mixing of a powder and a cream and applying it to the wounds. An interview was conducted on 4/5/22 at 12:18 pm with Resident #248 and it was indicated Nursing Assistants (NA ' s) were instructed to provide wound care by mixing of a powder and a cream and applying it to the wounds. On 4/6/22 an observation was made of NA #1 (Nurse #1 assisted) provide activities of daily living (ADL) care with Resident #248. NA #1 dried the resident ' s bottom area, she was in the process of applying a nystatin powder to Resident #248, however Nurse #1 stopped NA #1 and stated a Nurse needed to do the wound treatment. On 4/6/22 at 11:12 am an interview was	F 658	the potential to be affected by the alleged deficient practice. All residents with skin wounds have the potential to be impacted. On 05/02/2022 the Director of Nurses and wound nurse audited 100% of residents with skin wounds to assure that a treatment order was in place and being provided as ordered. Results: As of 05/02/2022 all residents with skin wounds were in compliance. On 05/02/2022 the Director of Nurses audited all treatment carts to assure that no medications without a supporting order to be administered, were found on the treatment cart. Results: No other identified concerns. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: Beginning on 5/02/2022 the Director of Nurses, Nurse Consultant began in-service education to all full time, part time, and as needed and agency nurses Topics included: • Obtaining treatment orders for all skin wounds. • Following physician orders for treatments orders. • Treatment error process. • Licensed nurse and role with the provision of treatments. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has	

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F 658	Continued From page 9 conducted with NA #1. She stated another Nurse had instructed her to apply the nystatin powder to Resident #248 ' s wounds. NA #1 stated she could not recall the Nurses name who instructed her to apply the nystatin powder. On 4/6/22 at 11:15 am an observation was made of Nurse #1 in the process of applying the nystatin powder to Resident #248 ' s wounds and the surveyor noted the nystatin prescription label had another person ' s name on it, not Resident #248 ' s. The surveyor stopped Nurse #1 due to the label on the powder having another person ' s name on it. Nurse #1 asked NA #1 where she got the powder from, and NA#1 stated she got it off the treatment cart. Nurse #1 left the room and returned with a bottle of Nystatin powder with Resident # 248 ' s name on the prescription label that read in part Nyamac (Nystatin topical powder 1000,000 USP units per gram 60 grams). Nurse #1 stated she needed to go check the order and again left the room. Nurse #1 returned to Resident #248 ' s room at 11:22 am and stated she was unable to find an order on the electronic medication record (EMAR), and she stated she was not sure if it was on the treatment administration record (TAR) because she was not able to access the TAR and maybe she wasn ' t able to access the TAR because she was from the Agency, she stated she would find out from the wound nurse and would wait to do the treatment. A review of Resident #248 ' s physician orders for April 2022 revealed no order for nystatin powder. On 4/6/22 at 11:47 am a follow-up interview was conducted with Nurse #1, and she stated she was from the Agency and had been at the facility for 3	F 658	been sustained. Any of the identified nursing staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by May 20, 2022. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing and/or designee will utilize the QA tool for F 658 to monitor compliance with the treatment order process. The Director of Nurses and/or designee will monitor 3 residents with skin wounds to assure treatment orders are in place and being administered as ordered weekly for 2 weeks, then monthly for 3 months for compliance with the ordered treatment. This tool will be completed as stated above or until such time that the QA Committee determines the need to change the frequency of the audit (when it has been determined that sustained compliance has been achieved). Identified area of concern are to be immediately addressed. The DON will present the results to the QA Committee. The monthly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager, Maintenance Director, Medical Director. Date of Compliance: 05/21/2022	

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F 658	Continued From page 10	F 658		

days. Nurse #1 added she found the nystatin powder on the treatment cart but could not find the order. She stated again maybe it was because she was from the agency. Nurse #1 indicated she informed the wound nurse the treatment needed to be done.

On 4/06/22 at 3:11 pm an interview was conducted with the Director of Nursing (DON), and he stated they did not have an order for the nystatin powder and believed Resident #248 was getting (nystatin powder) in the hospital and that was why the powder was in the facility. He stated his expectation was any medication or treatment order for any treatment was to have an order and to be done as ordered. He also indicated Resident # 248 was alert and oriented and probably brought the medication from the hospital when she admitted to facility.

On 4/7/22 at 2:00 pm an interview with the Wound Nurse was conducted and she stated she did not remember telling NA#1 or anyone else to get any medication off the treatment cart or to apply anything on Resident #248 ' s wounds. She stated there was no order for nystatin powder because when Resident #248 came from hospital, the order was on the discharge (d/c) summary, but the doctor did not want it ordered at the time. The Wound Nurse stated, "I never used nystatin powder on resident because there was no order."

A review of the d/c summary from the hospital dated 3/28/22 revealed medications: current discharge medication list for nystatin (myostatin) 100,00 unit/gram powder apply topical once daily.

On 4/7/22 at 2:20 PM a telephone interview was

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	345576	A. BUILDING _____ B. WING _____	C 04/08/2022

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F 658	Continued From page 11 conducted with pharmacy tech, and she stated the pharmacy received the d/c summary for Resident #248 with the medications list from the facility on 3/28/22 with the nystatin powder listed and that was why the pharmacy sent the nystatin powder. On 4/7/22 at 2:30 pm a follow up interview was conducted with the DON, and he indicated the discharge summary was sent to the pharmacy before the nystatin powder was removed from the order list, and they did not have an order for the nystatin powder.	F 658		
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 observations, record review, resident and staff interview the facility failed to serve food that was palatable and at an acceptable temperature for 2 of 5 residents (Resident #150 and Resident #154) that were reviewed for food palatability. Findings included: An observation was made of the steam table in the kitchen on April 6, 2022, at 12:20 PM. The	F 804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be	5/20/22

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F 804	Continued From page 12 lunch meal was already on the steam table and cook #1 revealed she had taken the temperatures already. Cook #1 used a digital thermometer to recheck the temperature of the food on the steam table and they were: tomato soup 195 degrees F, grilled cheese sandwich 187 degrees F, spring vegetable stick 168 degrees F and hamburger patties 187 degrees F. A test tray was prepared at 12:33 pm on April 6, 2022, from the kitchen steam table and contained tomato soup, grilled cheese sandwich, and spring vegetable stick. The test tray was delivered to the 200 hall with 14 resident meal trays at 12:37 pm. The last resident ' s meal tray was delivered at 12:55 PM. The Dietary Manager (DM) used the digital thermometer, and the food temperatures were tomato soup 154 degrees F, grilled cheese sandwich 90 degrees F, and spring vegetable stick 111 degrees F. The food items were tasted by the DM and surveyor. The soup was warm, the grilled cheese sandwich was hard to cut and cold and the spring vegetable sticks were hard and cold. The DM agreed that both the grilled cheese sandwich and spring vegetable sticks were hard and cold. During an interview with Resident #150 on April 6, 2022, at 1:10 PM, he stated it was hard to mess up a grilled cheese sandwich and soup, but his food was cold, and the grilled cheese sandwich was hard. Resident #150 indicated the vegetable sticks were nasty and cold. Observation of the resident ' s plate revealed he only took a few bites of the grilled cheese sandwich, spring vegetable stick and the soup. During an interview with Resident #154 on April 6, 2022, at 1:30 PM, he indicated that his lunch was	F 804	corrected by the dates indicated. F804 1. For dietary services, a corrective action was obtained on 05/2/2022. Based on observation, test tray, and resident and staff interviews it was noted the facility failed to provide palatable food to 2 of 5 residents. On 04/06/2022, Resident #150 was interviewed and stated the food was cold and the grilled cheese was hard. On 04/06/2022, Resident #154 was interviewed and identified the food as being served cold, hard, and not enough. Both residents discharged from facility with no further complaints regarding food since 04/06/2022. A test tray was completed 04/06/2022 for the 200 hall and evaluated by surveyor and dietary manager; test tray food items were found to be lukewarm and hard. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 05/02/2022, the Dietary Service Director completed an in-service to discuss dining experience with dietary staff and meal procedures with nursing/assistant nursing staff. Test Trays were initiated on 05/02/2022 will be incorporated twice weekly until food complaints reduce or resolve completely.	

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F 804	Continued From page 13 cold, hard, not enough and he wanted something else. During an interview with the DM on April 8, 2022, at 9:30 am she revealed she had only been at the facility for 2 weeks and had already received resident complaints about cold food. The DM added she had conducted some test tray checks and thought the reason the food was cold was because the trays set on the halls for a while before they were delivered to the residents. The DM indicated her staff did what was expected in the kitchen with insulated bases, closed food carts and kept food temperature above the requirement on the steam table. The DM stated it was her expectation that food was served timely, at the appropriate temperature and tasted good. During an interview with the Administrator on April 8, 2022, at 10:30 am, she stated it was her expectation that that all meals were served timely, were palatable and at an appropriate temperature.	F 804	An additional plate warmer was installed to assist with maintaining appropriate food temperatures on 04/29/2022. Test Trays were completed on all hallways on 05/02/2022 to ensure the last tray had acceptable temperatures prior to serving. Interviews were completed on 05/02/2022 to ensure satisfactory dining experience and that serving sizes were appropriate. Dietary Manager will attend resident council as invited and follow up with any food complaints as identified. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: • Meal objectives and procedures • Test Tray completion • Focus on dining experience Additional systemic changes: • Dietary manager has routinely perform line observations for lunch and dinner to monitor food preparation and provide cook training as needed. • Plate warmer installed to assist with temperature maintenance • All staff trained on timely serving of meal trays to ensure food is palatable. • Test Trays will be completed to ensure satisfactory dining experience • Dietary Manager will attend resident council as invited and follow up with any	

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F 804	Continued From page 14	F 804	food complaints as identified. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will complete a test tray daily x 2 weeks, weekly x 2 weeks, and then monthly x 3 months using the Dietary QA Audit. Monitoring will include reviewing food items for appearance and taste as well as visiting with residents when complaints are received. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 05/20/2022	