STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345208	A. BUILDING _____ B. WING _____	06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT BREVARD	115 N COUNTRY CLUB ROAD BREVARD, NC 28712

(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 05/31/22 through 06/3/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # Z2GB11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 05/31/22 through 06/03/22. Event ID # Z2GB11.	F 000		
F 584 SS=D	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	F 584		6/27/22

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

Electronically Signed | 06/23/2022

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F 584	Continued From page 1 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, 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 record review, observations, staff and resident interviews, the facility failed to maintain residents' window blinds in good repair for 1 of 5 sampled residents reviewed for a safe, clean, comfortable, homelike environment (Residents #49). The findings included: Resident #49 was admitted to the facility on 05/03/22. The admission Minimum Data Set (MDS) dated 05/10/22 coded Resident #49 with intact cognition, clear speech, and adequate hearing and vision. In an observation conducted on 05/31/22 at 12:19 PM, the window blinds for Resident #49 were broken on the right side with at least 10 blinds either missing or bent in the random directions, resulted with an opening approximately 7 inches	F 584	1. F584 Safe/Clean/Comfortable/ Homelike Environment was cited. Based on the findings, the window blinds in resident #49's room were noted to be bent or missing sections and there was the ability to view inside resident's room from the outside of the facility. To maintain compliance, blinds needed to be replaced. 2. A work order was entered into the facility work order system (TELs) on 6/2/22 by the Director of Nursing Services and the blinds were replaced on 6/2/22 with a window shade. DON and RDCS conducted walk through rounds with maintenance director on 6/2/22 and 2 additional blinds were also replaced at that time. In-service education for all staff was initiated on 6/2/22 regarding the procedure for reporting general maintenance and equipment concerns utilizing the facility's maintenance work	

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F 584	Continued From page 2 by 20 inches that people from outside of the window could see through. During an interview conducted with Resident #49 at the time of the observation, he could not recall how long the window blinds had been broken. He felt like people could see him from outside of the window when he was in the room and he wanted the maintenance staff to fix it as soon as possible. Subsequent observations conducted on 06/01/22 at 3:56 PM and 06/02/22 at 10:16 AM revealed Resident #49's window blinds remained in disrepair. During an interview conducted with Nurse #1 on 06/02/22 at 10:26 AM, she stated she did not notice Resident #49's window blinds had been broken. She explained she had been working in another hall on 05/30/22 and had a day off on 06/01/22. She added she would have notified the Maintenance Manager if she had noticed the window blinds were broken. Interview with NA #1 on 06/02/22 at 10:34 AM revealed he worked on the South hall 05/30/22 and had failed to notice the window blinds for Resident #49 had been broken. He stated the window blinds needed to be fixed as soon as possible and he would notify the Maintenance Manager immediately. During a joint observation conducted with the Maintenance Manager and the Director of Nursing (DON) on 06/02/22 10:42 AM, the Maintenance Manager and the DON agreed that the window blinds for the Resident #49 needed to be fixed immediately. The Maintenance Manager explained he was the only staff in the maintenance department and had routinely	F 584	order system (TELs) by the Director of Nursing and Assistant Director of Nursing. This education was completed by 6/27/22. Any staff not receiving education by this date will receive prior to next scheduled shift. This information will be presented in new hire and new contract staff orientation. 3. An additional audit of all resident room window blinds/shades was conducted on 6/10/22 by the Administrator and all blinds/shades that need to be replaced were entered into facility maintenance work order system (TELS). 4. The Interdisciplinary Team will monitor window blinds/shades during room rounds 3 times per week for 12 weeks. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery. 5. Completion date: 6/27/22	

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F 584	Continued From page 3 walked through the facility at least once weekly to identify maintenance or repair needs. He did not notice Resident #49's window blinds had been broken. He added he depended on the nursing staff to alert him via the work orders or verbal notification for most of the maintenance needs. An interview was conducted with the DON on 06/02/22 at 10:49 AM. She stated it was her expectation for all the window blinds to be in good repair all the time. During an interview conducted on 06/03/22 at 02:06 PM, the Administrator expected the staff to fully utilize the work order system to ensure all the repair or maintenance needs be met in a timely manner. It was his expectation for all the window blinds to be in good repair all the time. +	F 584		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 636		6/27/22

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F 636	Continued From page 4	F 636		

(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility

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F 636	Continued From page 5 following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete the Care Area Assessments (CAAs) comprehensively by not having the underlying causes and contributing factors in place for the analysis of findings for all the triggered areas for 1 of 9 sampled residents (Residents #52). The findings included: 1. Resident #52 was admitted to the facility on 04/08/22 with diagnoses included heart failure, hemiplegia, thrombocytosis, polyneuropathy, and muscle weakness. The admission Minimum Data Set (MDS) dated 04/12/22 coded Resident #52 with intact cognition, clear speech, and adequate hearing and vision. Resident #52 required limited staff assistance for most activities of daily living (ADL) and was independent with eating. Review of the CAAs for the admission MDS dated 04/12/22 revealed 11 areas were triggered for care plan consideration. It consisted of ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities, falls, dehydration/fluid maintenance, dental care, pressure ulcer/injury, psychotropic drug use, and pain. Further review of the CAA worksheets revealed no documentations were in place under the analysis of findings for each triggered area. There were no explanations for the issues	F 636	1. F636 Comprehensive Assessments & Timing was cited. Based on the findings, the CAA for resident #52 did not reflect documentation related to the triggered areas within the resident care plan and care areas. 2. CAA updated immediately for resident #52 by MDS Coordinator to reflect a resident centered POC with explanations, assessments, and documentation in the CAA to support. 3. Regional Clinical Reimbursement Consultant performed an audit of all resident care plans and CAAs beginning on 6/16/22. All areas corrected as needed. Education was provided by the Regional Clinical Reimbursement Consultant to the MDS coordinator on 6/14/22 to ensure that CAAs reflect resident POC and triggered areas within the care plan accurately. 4. Regional Clinical Reimbursement Consultant and team will audit resident care-plans and CAAS as routine assessments are due for current and new residents within facility x30 days. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for recommendations for a period of 3 months. Any concerns	

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F 636	Continued From page 6 checked and the CAAs did not contain an analysis addressing the nature of Resident #52's condition, the presence of causes and contributing factors, risk factors related to the care area, and the reasons for a decision to proceed with care planning for each care area triggered. On 06/01/22 at 2:48 PM an interview was conducted with the MDS Coordinator. He acknowledged that he was responsible for the completion of Resident #52's CAAs for the admission MDS dated 04/12/22. He explained when Resident #52 was admitted in April 2022, the facility did not have a social worker and he had to cover the tasks performed by the social worker. He was distracted and had forgotten to complete all the analysis of findings for Resident #52. He admitted that the CAAs were incomplete without the description of the nature of the problem, causes and contributing factors, risk factors, and reasons to proceed with care planning in the analysis of findings. An interview was conducted with the Director of Nursing (DON) on 06/02/22 at 10:14 AM. She stated all CAA assessments must be individualized. It was her expectation for the MDS Coordinator to complete all the CAA assessments comprehensively before submission. On 06/03/22 at 2:06 PM an interview was conducted with the Administrator. It was his expectation for all the CAAs to be completed individually and comprehensively.	F 636	identified will be addressed at time of discovery. 5. Completion Date: 6/27/22	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		6/27/22

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F 657	Continued From page 7 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to notify or invite 1 of 3 sampled residents to care plan meetings (Resident #33). Findings Included: Record review revealed Resident #33 was admitted on 9/23/21 and was her own responsible party.	F 657	1. F657 Care Plan Timing and Revision was cited. Based on the findings, the facility IDT team (MDS Coordinator, Director of Nursing Services, Assistant Director of Nursing Services, Therapy Director, Activity Director, Dietary Manager and Social Worker) failed to invite resident #33 to her care conference held on 9/27/21. She is her own responsible party. Resident stated during	

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F 657	Continued From page 8 There were a total of three Minimum Data Set (MDS) assessments completed for Resident #33 after her admission MDS. The last had an Assessment Reference Date (ARD) of 4/21/22. The quarterly Minimum Data Set (MDS) completed on 5/4/22 revealed the Resident to be cognitively intact. On 5/31/22 at 11:58 AM an interview with Resident # 33 revealed the Resident had not been invited to attend care plan conference meetings with the Interdisciplinary Team (IDT) to discuss her care and goals. Resident #33 indicated she would attend the care plan meetings if invited. Resident #33 recalled meeting with the IDT after her initial admission to the facility. The Interdisciplinary Care Plan Assessment indicated a care plan conference was completed with the resident on 9/27/21. Record review revealed no other care plan conference with Resident #33's notification/attendance. During an interview with the MDS Coordinator on 6/1/22 at 1:26PM, it was revealed that care plan meetings were completed upon admission with the IDT and resident or Responsible Party. The IDT then had them on a quarterly basis following the ARD or when there was a significant change assessment completed. The MDS Coordinator explained that the IDT would go and talk to the resident in the room if they were able to participate. The MDS Coordinator said the facility was currently without a Social Worker (SW) and the SW was the one responsible for communicating to the resident about Care Plan Meetings. The SW would also document any	F 657	interview on5/31/22 that she would come if invited. 2. Care plan meeting held with resident #33 on 6/20/22 with invitation letter addressed and hand delivered to her by DON. 3. The MDS Coordinator will pull the Care Plan Reviews Due Report from PCC on a bi-weekly basis and distribute to all IDT members. IDT members will prepare care conference invitation for all residents for a 2-week time frame and present the list and invitation to the Administrator to sign off after invitation has been delivered to resident, call placed to RP, etc., with response. A copy of both the list and invitation will be given to the Administrator. A copy of care conference invitations and response with any resident signature will be scanned into the resident record. Education was provided on 6/14/22 by the Regional Clinical Reimbursement Director to the MDS Director of the requirement to give each resident or resident representative the opportunity to attend their care plan meeting if desired. 4. Administrator or other member of the IDT team assigned will audit the care plan conference invitation and attendance list 3 times per week for 12 weeks. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for recommendations for a period of 3 months. Any concerns	

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F 657	Continued From page 9 resident refusals or if the Responsible Party did not respond. The former SW was interviewed on 6/1/22 at 3:32. The SW said he would call families and invite them to care plan meetings and that he kept a logbook of it. He was not sure of where the book was. The SW recalled doing phone calls with Resident #33 and her brother for care plan updates but could not recall when these phone calls occurred. He indicated he may have overlooked documenting the meetings. The Director of Nursing (DON) reported in an interview on 6/2/22 at 3:57 PM that normally the SW would contact the resident and the Responsible Party to coordinate the care plan meeting. The SW last worked on 3/9/22, and the task has been divided up among the IDT. An interview with the Administrator on 6/03/22 at 01:40 PM revealed that residents and family members should be invited to attend care plan meetings and it should be documented per facility policy.	F 657	identified will be addressed at time of discovery. 5. Completion date: 6/27/22	
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, resident, resident representative, staff interviews and record review, the facility failed to provide toenail care to 1 of 7 residents reviewed for toenail care (Resident	F 677	1. F677 ADL Care Provided for Dependent Residents was cited. Based on the findings, residents #18s toenails were too long and her representative had	6/27/22

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F 677	Continued From page 10 #18). The findings included: Resident #18 was readmitted to the facility on 9/30/2019 with diagnoses which included unspecified dementia without behavioral disturbance and need for assistance with personal care. An annual Minimum Data Set (MDS) assessment dated 3/28/2022 revealed Resident #18 was moderately cognitively impaired and required limited assistance with personal hygiene. The MDS assessment did not indicate any rejection of care. A care plan dated 4/8/2022 revealed a focus area for activities of daily living (ADL) self-care deficit related to dementia with interventions which included to provide assistance to Resident #18 with bathing/showering. Review of progress notes from February 2022 through 6/2/2022 did not reveal any notes related to toenail care or refusal of care. During an interview with Resident #18's representative on 5/31/2022 at 3:55 PM, she reported Resident #18's toenails were very long, and she had requested they be trimmed about 2 weeks ago. Resident #18's representative was not able to recall who she spoke with at the facility, however when she rechecked Resident #18's toenails on Friday 5/27/2022 they had still not been trimmed. An interview with Resident #18 and an observation of Resident #18's toenails on	F 677	asked for them to be trimmed prior. 2. Nails were cut by wound care nurse on 6/2/22. An appointment with an outside podiatrist was made for resident #18 at 11: 00am, Thursday, June 16, 2022. 3. An assessment of all resident nails was conducted on 6/6/22 and 6/7/22 by nursing staff with Director of Nursing oversight. Nail care was provided to any resident identified at that time. During this assessment, all residents identified who need to see a podiatrist were added to the podiatry list for the podiatrists next facility visit on 6/28/22. In-service education for nursing staff was initiated on 6/2/22 regarding nail care and scheduling residents for podiatry visits and other ancillary services, by the Director of Nursing and Assistant Director of Nursing. This education was completed by 6/27/22. Any staff not receiving education by this date will receive prior to next scheduled shift. This information will be presented in new hire and new contract staff orientation 4. The Director of Nursing Services and Assistant Director of Nursing Services will monitor resident nails during room rounds 3 times per week for 12 weeks. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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F 677	Continued From page 11 5/31/2022 at 4:20 PM revealed the 2nd, 3rd, and 4th toenails on the right foot and the 2nd, 3rd, and 5th toenails on the left foot were thick and were all approximately 5 millimeters long. The 2nd toenail on the right foot was curved towards the great toe. Resident #18 reported she did not like for her toenails to be that long and wanted them to be cut but was not able to cut them herself. Follow up observations of Resident #18's toenails on 6/1/2022 at 4:15 PM and 6/2/2022 at 10:00 AM revealed Resident #18's toenails had not been trimmed. An interview with Nurse #3 on 6/2/2022 at 1:03 PM revealed Nurse #3 was assigned to Resident #18 on 5/21/2022 and had given her a shower that day. Nurse #3 further revealed she had attempted to trim Resident #18's toenails on 5/21/2022 because they were long, however was not able to because of the length and thickness of the toenails. Nurse #3 stated she did not report this issue to any other staff member or the DON. Nurse #3 further stated she should have reported it to the DON and did not know why she had not reported it. An interview with Nurse #4 on 6/3/2022 at 9:54 AM revealed Nurse #4 was assigned to Resident #18 on Monday 5/30/2022 and was supposed to have given Resident #18 a shower that day but had switched with another staff member, NA #2. Nurse #4 further revealed she was not made aware that Resident #18's toenails were long. Nurse #4 stated she had special nail clippers that typically worked on long, thick nails and would have attempted to trim Resident #18's nails if she was aware of the issue. Nurse #4 further stated if	F 677	5. Completion date: 6/27/22	

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	345208	A. BUILDING _____ B. WING _____	06/03/2022

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F 677	Continued From page 12	F 677		

she was not able to trim the toenails, she would have notified the NP so the issue could have been addressed.

A follow up interview with NA #2 on 6/3/2022 at 10:01 AM revealed NA #2 had given Resident #18 a shower on Monday 5/30/2022 and did recall observing Resident #18's toenails to be long. NA #2 further revealed she did not report the long toenails to the nurse. NA #2 indicated she should have reported the long toenails to the nurse and was not sure why she did not report it.

An interview and observation of Resident #18's toenails with Nurse Aide (NA) #2 6/2/22 at 10:09 AM ,who was assigned to Resident #18, revealed toenails were typically trimmed on shower days, and she had seen Resident #18's left toenails that morning however she had not seen her right toenails because Resident #18 had already put her right shoe on her foot prior to NA #2 coming to the room to assist Resident #18. NA #2 further revealed Resident #18's toenails were very long and did need to be trimmed.

An interview and observation of Resident #18's toenails with Nurse #2 on 6/2/22 at 10:27 AM, who was assigned to Resident #18, revealed toenails were typically trimmed on shower days and as needed. Nurse #2 reported she had not seen Resident #18's toenails and typically the nurse aides would let the nurses know if a residents' toenails were long, however Nurse #2 stated she had not been notified Resident #18's toenails were long. After observation of Resident #18's toenails, Nurse #2 revealed Resident #18's toenails were long and did need to be trimmed.

An interview and observation of Resident #18's

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F 677	Continued From page 13 toenails with the Director of Nursing (DON) on 6/2/2022 at 10:34 AM revealed toenails were typically trimmed on shower days and if the resident was not diabetic, nurse aides were able to trim toenails. The DON further revealed she had not received any reports of Resident #18 having long, thick toenails. The DON reported Resident #18 would refuse care at times but was not sure if Resident #18 had refused toenail care. After observation of Resident #18's toenails, the DON stated Resident #18's toenails did need to be trimmed. A follow up interview with the DON on 6/3/2022 at 2:03 PM revealed staff should have reported Resident #18's long toenails to the nurse on the hall or to the DON so the issue could have been addressed.	F 677		
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	F 812		6/27/22

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F 812	Continued From page 14 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard expired food items stored for use in 2 of 4 refrigerators (walk-in refrigerator, north nourishment room), expired ready to use thickened liquids and an expired ready to use nutritional supplement in 1 of 1 dry storage areas. This practice had the potential to affect food served to residents. The Findings Included: 1a. An observation completed with the Dietary Manage (DM) in the walk-in refrigerator on 05/31/22 at 9:55 AM revealed an open box of individually wrapped cucumbers totaling 4 whole and 1 half. The box was dated as received on 5/2/22. All cucumbers had black spots on them and were soft and mushy when touched. Juice was observed dripping from the bottom of the cucumber box onto a closed plastic container of meat when the cucumber box was moved. b. An opened box of fresh sliced mushrooms was observed on the top shelf in the walk-in refrigerator. The box was observed to be nearly empty and contained several slimy mushrooms. A received date of 5/16 was written on the box. c. An opened box containing 11 of 12 bags of individually wrapped deli turkey bags located on the top shelf with a use or freeze by date of 5/17/22 on the box. No other date was on the box. An interview with the DM on 5/31/22 at 9:55AM	F 812	1. F812 Procurement Store/Prepare/Serve Sanitary was cited. Based on the findings, the surveyor noted two items to be expired on 5/31/22 in the kitchen and nourishment room areas. 2. The expired food items in the walk-in refrigerator, north unit nourishment room refrigerator, and dry storage area were immediately discarded on 5/31/22 by the dietary manager. An audit of all refrigerators including nourishment room refrigerators was conducted on 5/31/22 by Dietary Manager and Regional Director of Culinary Services, Next Level Hospitality Services. All expired items, and/or items not labeled and dated were immediately discarded. 3. In-service education for all dietary staff was initiated on 5/31/22 by Regional Director Culinary Services, Next Level Hospitality Services, regarding the procedure for checking refrigerators and storage areas for outdated/expired items and items not labeled/dated based on facility policy and that any expired/outdated item and/or items not labeled and dated should immediately be discarded based on facility policy. This education was completed by 6/27/22. Any staff not receiving education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation.	

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F 812	Continued From page 15 during the observation found that the facility had only recently started ordering cucumbers and mushrooms to make daily salads for a resident's request. The DM said the last time a salad was made occurred on 5/26/22. The DM also said the deli turkey had been frozen until 5/27/22 when it was taken out to thaw. 2. An observation with the DM on 05/31/22 at 10:14 AM in the dry storage area revealed multiple expired ready to use thickened liquid cartons. The expired containers included 24-32 once nectar thick consistency milk containers with various expiration dates, 2 honey thick consistency tea cartons with expiration date 2/24/22, 8 cartons of honey thick apple juice with expiration date 4/12/22, 1 honey thick dairy drink with expiration 2/16/22, and 19-8 once mildly thick dairy drink with expiration 3/16/22. Also observed was one -32 once container of Med Plus NSA 1.7 (high calorie-high protein nutrition drink) with expiration of 11/22/21. Some thickened milk containers where found mixed in with the expired containers that where still within expiration date. During the observation, the DM reported that the expired containers were placed on the left side of the shelf to inventory them for reimbursement. The DM was unsure of how the containers were mixed up and said that she was responsible for checking the stock for expiration 3. On 6/2/22 at 12:30 PM, an observation of the north nourishment room refrigerator revealed a clear plastic bottle half-full that contained a brown/cream colored substance in the door shelf. The container was not dated and did not have a label indicating the contents. The refrigerator also contained several outdated Styrofoam cups with lids labeled applesauce dated 5/24-6/1.	F 812	4. The Administrator, Dietary Manager, and Registered Dietitian will monitor nourishment room refrigerators and dry storage areas 3 times per week for 12 weeks. Results of the monitoring will be presented to the Quality Assurance and Performance Improvement Committee by the Administrator for recommendations for a period of 3 months. Any concerns identified will be addressed at time of discovery. 5. Completion date: 6/27/22	

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F 812	Continued From page 16 An interview with the DM on 6/02/22 at 1:52 PM revealed that a paper was on the side of the refrigerator that says all food must be dated and labeled before putting it in the refrigerator. The DM indicated that the nourishment rooms were checked daily, and they disposed of any items not labeled and dated. The applesauce was made every 3 days and then replaced. The Administrator was interviewed on 6/03/22 at 1:40 PM. He reported that anything outdated should be discarded, and food storage should be rotated and checked for expired items. Anything outdated should be discarded as per facility policy.	F 812		