STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345331	A. BUILDING _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARDIS OAKS	5151 SARDIS ROAD CHARLOTTE, NC 28270

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/11/23 through 04/14/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LTLF11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/11/23 through 04/14/23. Event ID # LTLF11. The following intake was investigated: NC00200557. 1 of 2 complaint allegations resulted in a deficiency.	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		5/12/23

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

Electronically Signed | 05/08/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 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 maintain dignity for 1 of 3 residents with an uncovered urine collection bag for public view (Resident # 44). The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity and would not want their urine visible to visitors, staff and other residents. The findings included: Resident #44 was admitted to the facility on 10/28/2022. Resident #44 had diagnoses that included urinary retention and chronic kidney disease. Resident #44's most recent Minimum Data Set (MDS) dated 2/2/2023 revealed Resident #44 was severely cognitively impaired and required	F 550	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F550 On 4/14/23, the Director of Nursing was made aware that Resident #44 did not consistently have a privacy cover on his catheter bag. The Director of Nursing addressed the issue with staff and corrected the deficient practice for this resident.	

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F 550	Continued From page 2 extensive assistance for activities of daily living. Resident #44 had an indwelling urinary catheter in place. Resident #44 was not coded as having any behavioral symptoms. An observation was completed from the doorway of Resident #44's room on 4/11/2023 at 10:30AM. Resident #44 was observed sitting up in his wheelchair. The urine collection bag was visible from the hallway, hanging on the side of the wheelchair, which contained amber colored urine with no privacy cover. A follow up observation was completed on 4/11/23 at 3:09PM. Resident #44 remained up in his wheelchair. Resident #44's urine collection bag, which contained amber colored urine, continued to be observed from the hallway with no privacy cover. An interview was conducted on 4/14/2023 at 3:10 PM with NA #5. NA #5 stated that she worked with Resident #44 on Monday 4/10/23 and Tuesday 4/11/23. NA #5 was unaware that Resident #44's urine collection bag was without a privacy bag on 4/10/23 and 4/11/23. Additional observations were completed on 4/13/2023 at 3:15 PM, 4/14/23 at 7:45 AM and 9:29AM. During all three additional observations, Resident #44 was observed sitting up in his wheelchair in his room. Resident #44's urine collection bag, which contained amber colored urine, continued to be observed from the hallway with no privacy cover. On 4/14/23 at 2:39 PM Resident #44 was observed with a privacy cover on his urinary catheter bag.	F 550	By 5/12/23 all nursing staff will be in-serviced by the Director of Nursing or designee to ensure residents□ catheter bags have a privacy cover in place. Any nursing staff members who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. The process for covering catheter bags will change to ensure all catheter bags have a privacy cover in place. We will be using new catheter bags that include a built-in privacy cover. All residents with catheter bags will have a built-in privacy cover in place by 5/8/23. Beginning 5/8/23, the Nurse Supervisor or designee will conduct three observations a week for 12 weeks to ensure privacy covers are in place covering catheter bags. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction date is 5/12/23.	

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F 550	Continued From page 3 An interview was conducted on 4/14/2023 at 2:40PM with NA #3. NA #3 stated that she worked with Resident #44 on 4/12/2023, 4/13/,2023 and 4/14/2023, as he required extensive assistance to total care. NA #3 stated that Resident #44 does have a catheter bag and that she was sure to position it correctly with a privacy cover bag for dignity. NA #3 stated that Resident #44 had an appointment this morning and did not have a cover bag for privacy. NA #3 stated that nursing staff were responsible for providing the privacy bag for catheters, which were kept in the supply room. NA #3 was uncertain if Resident #44 had a privacy cover bag prior to leaving for his appointment. An interview was completed on 4/14/2023 at 3:05 PM with Nurse #2. Nurse #2 stated she checked Resident #44's urine collection bag each shift. Nurse #2 stated that there was usually a cover bag for dignity. She further stated they always covered the catheter bags during the day. Nurse #2 verbalized that she went to get a privacy bag this morning prior to Resident #44's appointment. Nurse #2 was not aware the urine collection bag needed a privacy cover until 4/13/2023 before Resident #44's appointment. An interview was completed with the Director of Nursing (DON) on 4/14/23 at 3:32 PM. The DON stated that if a resident had a catheter bag that a privacy cover bag should be in place for dignity purposes. The DON stated that nursing staff were responsible for checking and providing privacy cover bags.	F 550		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		5/12/23

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F 677	Continued From page 4 §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 and staff interviews, and record review, the facility failed to provide hand hygiene for a resident who required extensive to total assistance for 1 of 1 resident reviewed for activities of daily living care (Resident #2). The findings included: Resident #2 was originally admitted to the facility 4/10/15, with diagnoses that included stroke, vascular dementia, hemiplegia, and left-hand contracture. Resident #2's care plan revised on 11/22/22 for Activities of Daily Living (ADL) self-care performance deficit due to multiple cerebral vascular accidents (CVAs) with left spastic hemiplegia. Interventions included: assist Resident with the level of support needed. Resident #2's annual Minimum Data Set (MDS) dated 1/06/23 revealed she was cognitively intact with no rejection/refusal of care documented. Resident #2 required total assistance with eating, toilet use, personal hygiene, and bathing. Resident #2 had range of motion (ROM) limitations of upper extremities. An observation made on 4/12/23 at 8:52 AM, Resident #2 revealed she had a dark substance on and underneath the fingernails of the right	F 677	F677 On 5/4/23, Nurse Aide #4 was in-serviced by the Director of Nursing on proper hand hygiene for Resident #2. On 5/3/23, Occupational Therapy conducted a re-assessment for Resident #2 to address the importance of overall hand hygiene, frequent checks for skin patency, and cleanliness of her left-hand contracture to prevent skin breakdown. The recommendations were shared with the interdisciplinary team. The care plan will be updated with the appropriate interventions. By 5/12/23 all nursing staff will be in-serviced by the Director of Nursing or designee on the importance of proper hand hygiene for residents who require extensive to total assistance. Any nursing staff members who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 5/12/23 the process for providing proper hand hygiene for residents who require extensive to total	

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F 677	Continued From page 5 hand. Resident #2's left hand was contracted; she was unable to fully open her hand to show her fingernails. Observation and interview on 4/13/23 at 9:03 AM, Resident #2 was sitting in reclining chair in hallway. The fingernails on Resident #2's right hand was observed with a dark brown substance on them. Resident #2 reported her hands were not washed that morning and they were sticky. An observation on 4/13/23 at 5:05 PM, of incontinent and ADL care with Nursing Assistant (NA) #4, no hand hygiene was provided. NA #4 said hand hygiene wasn't provided after incontinent care because Resident #2 did not use her left hand to play in feces. The hand was contracted. Resident #2 used the right hand to smear feces. NA #4 then washed Resident #2's right hand with a wet washcloth removing the brown substance that was visible on her hand. An interview on 4/14/23 at 9:53 AM, the Occupational Therapist (OT) stated Resident #2 was discharged from therapy in January of 2023. OT indicated the importance of hand hygiene was stressed to the nursing staff. OT said Resident #2 required frequent checks for skin patency and cleanliness due to having a left-hand contracture. Washing then thoroughly drying the contracture hand was important to prevent skin breakdown. The Occupational Therapist further explained, Resident #2 had behavior and reached into her brief, this required that nursing check her hands often and especially before meals and during incontinent care. During an interview on 4/14/23 at 10:56 AM, the Unit Supervisor stated hand hygiene and	F 677	assistance will change. Hand hygiene will now be performed after peri-care is provided for each resident who requires extensive to total assistance. Beginning 5/12/23, the Director of Nursing or designee will conduct three observations a week for 12 weeks to ensure proper hand hygiene for residents who require extensive to total assistance was provided. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 5/12/23.	

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F 677	Continued From page 6 cleanliness was a very important part of resident care. She stated that nursing staff needed to wash hands with soap and water often, especially since Resident #2 had a contracture and reached in her incontinent garment regularly. An interview on 4/14/23 at 1:40 PM, the Director of Nursing (DON) revealed that hand hygiene was performed on all residents prior to meals and when soiled. The DON said the staff used soap and warm water or sanitizing wipes to clean a resident's hands. Nursing staff needed to ensure both of Resident #2 hands were clean and dry, especially since she had a hand contracture.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		5/12/23

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F 690	Continued From page 7 and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Nurse Practitioner and Hospice Nurse interviews, the facility failed to obtain orders for suprapubic catheter care for 1 of 1 resident reviewed for catheter use. (Resident #39) The findings included: Resident #39 was admitted to the facility on 01/14/21 and readmitted on 11/04/22 with diagnoses that included traumatic spinal cord dysfunction and neurogenic bladder. Resident #39's care plan updated and reviewed on 11/14/22, revealed alteration of elimination related to spinal cord dysfunction that required suprapubic catheter. The interventions included provide routine care, change suprapubic catheter as ordered, and empty the catheter bag every shift and as needed. Resident #39's quarterly Minimum Data Set (MDS) dated 02/11/23 revealed Resident #39 was	F 690	F690 Suprapubic catheter care orders were entered on 4/14/23 for Resident #39. By 5/12/23 nurses will be in-serviced by the Director of Nursing or designee on obtaining and entering orders for suprapubic catheter care. Any nurses who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 4/21/23 the process for obtaining and entering orders for suprapubic catheter care changed. All suprapubic catheter orders will now require a physician□s order to be entered. This order will automatically trigger a task for completion of catheter care by the nurse.	

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F 690	Continued From page 8 cognitively intact and had a catheter for urination. Review of Resident #39's electronic medical record dated 01/1/23 through 04/14/23 revealed no physician orders for suprapubic catheter or suprapubic catheter care. An observation and interview on 04/12/23 at 09:14 AM, revealed Resident #39 had a suprapubic catheter in place. During the interview Resident #39 reported she had the suprapubic catheter in place before her admission to the facility. During an interview on 04/14/23 at 08:38 AM Nurse #1 explained she was aware Resident #39 had a catheter in place. She stated she would read and follow the physician orders to know what care needed to be provided to Resident #39. Nurse #1 was observed reviewing the physician orders in the electronic record for Resident #39 and verbalized Resident #39 had no catheter orders in place. An interview on 04/14/23 at 08:39 AM with the Director of Nursing (DON) was completed. She reported she could not locate the orders for suprapubic catheter care in the electronic record for Resident #39. A follow up interview was conducted with the DON on 04/14/23 at 10:35 AM. She stated the suprapubic catheter, and its care required a physician order. An interview was conducted on 04/14/23 at 10:29 AM with the Unit Coordinator who stated she was unable to locate the physician orders for catheter care for Resident #39. She communicated there was a task in the computer for catheter care, but no physician order for catheter care for Resident	F 690	Beginning 5/8/23, the Nurse Supervisor or designee will audit 100% of suprapubic catheter care orders for 12 weeks to ensure they are obtained and entered. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 5/12/23.	

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F 690	Continued From page 9 #39. She further explained when a resident had a suprapubic catheter in place, they were seen by Urologist initially and if there were no issues the facility Physician took over the care. She was unbale to recall the last time Resident #39 had been seen by urology. The Unit Manager verbalized she would contact the physician to obtain an order for suprapubic catheter care for Resident #39. A follow up interview was conducted with the DON on 04/14/23 at 10:35 AM. She stated the suprapubic catheter, and its care required a physician order. DON did say the order was probably there previously, but after the system change in December the order must have fallen off. She was unable to find any information related to the order.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff, interviews, the facility failed to obtain a physician order for the use of supplemental oxygen for 1 of 1 resident reviewed for oxygen use (Resident #39).	F 695	F695 Supplemental oxygen orders were entered on 4/14/23 for Resident #39. By 5/12/23 nurses will be in-serviced by	5/12/23

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F 695	Continued From page 10 The findings included: Resident #39 was admitted to the facility on 01/14/21 and readmitted on 11/04/22 with diagnoses that included respiratory failure, pulmonary fibrosis, and dependence on supplemental O2. Resident #39's care plan updated on 11/14/22 revealed Resident #39 was at risk for respiratory distress related to diagnoses of pulmonary fibrosis, pulmonary hypertension, and congestive pulmonary obstructive disease. The interventions included: administer oxygen as ordered, evaluate the effectiveness of oxygen, and vital signs as ordered. Resident #39's quarterly Minimum Data Set (MDS) dated 02/11/23 revealed Resident #39 was cognitively intact. A review of Resident #39's electronic medical record (eMAR) revealed no active/current physician orders for supplemental oxygen use or monitoring of oxygen saturation (amount of oxygen in the blood). Observation of Resident #39 on 04/11/23 at 11:36 AM revealed Resident #39 was lying in bed with her eyes shut. Resident #39 had O2 oxygen tubing in her nose. Her oxygen concentrator was observed running and set at 4.5 liters (L). Observation and interview with Resident #39 on 04/12/23 at 09:14 AM showed Resident #39 was sitting up in bed and she had oxygen tubing in her nose. The oxygen concentrator was running on 4.5 L. Resident #39 reported oxygen should be set to 2- 3 L. She stated she had lung disease	F 695	the Director of Nursing or designee on obtaining and entering supplemental oxygen orders. Any nurses who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 4/21/23 the process for obtaining and entering orders for supplemental oxygen changed. All supplemental oxygen orders will now require a physician□s order to be entered. This order will automatically trigger a task for provision of supplemental oxygen by the nurse. Beginning 5/8/23, the Nurse Supervisor or designee will audit 100% of supplemental oxygen orders for 12 weeks to ensure they are obtained and entered. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 5/12/23.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11 and her oxygen saturations would drop quickly without oxygen. Resident #39 expressed she has been on oxygen continuously for about 3 years. Observation of Resident #39 on 04/13/23 at 08:54 AM revealed Resident #39 lying in bed with her eyes closed and her oxygen concentrator running at 4 L. Resident #39 had oxygen tubing in her nose. During an interview on 04/14/23 at 08:38 AM with Nurse #2 it was revealed that Nurse #2 would refer to physician orders to see how much oxygen Resident #39 should receive. After checking the eMAR Nurse # 2 reported there were no orders for oxygen. Nurse #2 continued with her medication pass. An interview with Unit Coordinator on 04/14/23 at 10:29 AM revealed there needed to be a physician's order for O2 and O2 saturation monitoring in the electronic record. After looking in Resident #39's electronic record the Unit Coordinator said that there were no active/current orders in place for oxygen. Unit Coordinator stated she knew Resident #39 had been receiving oxygen. Unit Coordinator further explained orders for oxygen were received by the Physician, but she believed the order fell off the eMAR during the system conversion in December. An interview with DON on 04/14/23 at 10:35 AM revealed after looking for more information, she was unable to find the orders. She did say there should have been a physician order in place for how much oxygen to administer.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		5/12/23

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	345331	A. BUILDING _____ B. WING _____	C 04/14/2023

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F 812	Continued From page 12 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 observations, record review and vendor and staff interviews, the facility failed to sanitize dishware for meal service by failing to ensure the wash and final rinse cycles of the low temperature dish machine operated at accurate temperatures for 2 of 2 observations. This practice had the potential to affect food served to all residents. The findings included: Review of service reports from the external vendor for the dish machine revealed the following: 01/13/23 revealed documented wash temperature	F 812	F812 A bad fuse was discovered in the hot water heater that supplies the hot water to the dish machine. This fuse was replaced on 5/3/23 and is now providing appropriately hot water to the dish machine to meet temperature requirements. By 5/12/23 all dietary staff will be in-serviced by the Dietary Manager to ensure staff know the required minimum temperature for the wash and rinse cycle; and that staff know to re-check the temperature gauge in the middle of the	

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F 812	Continued From page 13 of 113 degrees Fahrenheit 02/06/23 revealed documented wash temperature of 115 degrees Fahrenheit 04/07/23 revealed documented wash temperature of 116 degrees Fahrenheit These documented temperatures fell under the minimum requirement of 120 degrees Fahrenheit for the low temperature dish machine. The service reports contained no recommendations but had been signed by the Dietary Manager. A continuous observation of the dish machine area was conducted on 04/12/23 at 2:00 PM revealed the low temperature dish machine in use. During the observation, Dietary Aide #1 loaded trays of soiled dishes into the dish machine. Observations of the dish machine's wash and rinse cycles revealed the following: A total of 10 trays had been washed and rinsed at a temperature of 115 degrees Fahrenheit, 15 small dessert bowels had been washed and rinsed at a temperature of 100 degrees Fahrenheit, and 16 trays were washed and rinsed at a temperature of 114 degrees Fahrenheit. All temperatures were observed by the surveyor on the dish washer's temperature gauge. On 04/12/23 at 2:05 PM an observation and interview with Dietary Aide #1 was conducted in the dish machine area revealed that an initial temperature check was done by observing the wash and rinse gauge located at the bottom of the dish machine. Dietary Aide #1 stated that once a temperature of 120 degrees Fahrenheit had been reached on the wash and rinse gauge then the dish washing process would be started. She verbalized it took 2 to 3 wash and rinse	F 812	wash and rinse cycle to ensure the temperatures remain compliant. Any staff members who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. The Administrator and Plant Operations Manager will be added to the dish machine vendor's monthly service report. This report includes a test of the water temperature. If the water temperatures are not within regulatory requirements, the Plant Operations Manager will initiate a work order to investigate and make any necessary repairs. Beginning 5/8/23, the Plant Operations Technician and/or designee will audit the dish machine water temperature three times per week for 12 weeks to ensure the wash and rinse cycle of the low temperature dish machine operates at accurate temperatures. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date is 5/12/23.	

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F 812	Continued From page 14	F 812		

cycles for the dish machine to reach the minimum temperature of 120 degrees Fahrenheit on the wash and rinse gauge. Dietary Aide #1 was not certain if this temperature was maintained throughout the duration of the dish washing and rinsing process. Dietary Aide #1 was unaware the dish machine was not reaching the minimum temperature of 120 degrees Fahrenheit throughout the dish washing process as indicated by observing the wash and rinse gauge.

An observation of the dish machine on 04/12/23 at 2:15 PM with the Dietary Manager was completed. He entered the kitchen and proceeded to check the dish machine. An internal test temperature was done on the dish machine by the Dietary Manager. The wash cycle temperature revealed 108 degrees Fahrenheit. The rinse temperature revealed 119 degrees Fahrenheit. The Dietary Manager used test strips to check the sanitation which revealed the dish machine was sanitizing properly. The Dietary Manager verbalized the dish machine was working properly after several wash and rinse cycles had been completed to reach the minimum temperature of 120 degrees Fahrenheit.

On 04/14/23 at 9:23 AM an observation and interview were completed in the dish washing area with Dietary Aide #2. The observation revealed that a rack of utensils and approximately 10 trays were washed at 106 degrees Fahrenheit and rinsed at 112 degrees Fahrenheit. Dietary Aide #2 stated that washing and rinse temperatures should be at least 120 degrees Fahrenheit. He explained once he loaded the dish machine that he did not recheck the temperature of the dish machine throughout the dish washing process. Dietary Aide #2 was

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F 812	Continued From page 15	F 812		

unaware the dish machine was not reaching the minimum temperature of 120 degrees Fahrenheit throughout the dish washing process as indicated by observing the wash and rinse gauge.

On 04/14/23 at 9:50 AM an interview was completed with the vendor representative, and he explained the facility had a low-temperature dish machine and that the wash and rinse temperatures should be at minimum 120 degrees Fahrenheit. He also stated that when he'd serviced the facility's dish machine the temperatures could fluctuate due to the piping and residual cold water in the machine. The vendor representative stated that when continuous cycles had been ran the dish machine had reached the appropriate temperature with no concerns. The vendor representative expressed that he'd completed the services in January 2023, February 2023, and April 2023 with documented wash temperatures of 113, 115, and 116 respectively. His recommendation to the facility had been to run several wash and rinse cycles prior to completing any dishes to ensure the temperatures were reaching the minimum 120 F. He stated he would assess the dish machine and possibly change out the gauge.

At 04/14/23 at 10:15 AM the surveyor observed the vendor representative onsite changing the dish machine gauge. A brief interview was conducted with the vendor representative, and he stated that the gauge was minus 5 to minus 6 degrees off. The vendor representative had been unaware how long the dish machine had been minus 5 to minus 6 degrees off from the minimum temperature of 120 degrees Fahrenheit. Several wash and rinse cycle temperatures were then completed once the

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F 812	Continued From page 16	F 812		

gauge had been replaced.

On 04/14/23 at 10:19 AM an interview with the Dietary Manager was completed. He stated the loader (staff person responsible for rinsing the dishes and loading the dish machine) would obtain the temperature of the dish machine prior to starting a wash cycle with facility dinnerware and utensils. He continued to explain once the minimum temperature of 120 degrees Fahrenheit had been reached staff would not stop to spot check or observe the wash and rinse gauge to ensure the wash and rinse temperatures were being maintained throughout the process. The Dietary Manager explained at the end of the dish washing process staff would obtain a final temperature.
MOn 04/14/23 at 10:41 AM an interview was conducted with the maintenance director who stated he had not been aware of any concerns related to the dish machine not reaching temperature. He further stated that those issues would be reported to the manufacturer for any repair issues.

On 04/14/23 at 11:30 AM a follow up interview was completed with the Maintenance Director related to the dish machine. He explained that he had no prior work orders related to the dish machine nor had he received the service reports. He stated that in this facility he would receive a work order for the repairs to the dish machine and that he had not received any work orders.

At 2:05 PM on 04/14/23 an interview was conducted with the Director of Nursing (DON). She stated that she was unaware of the issues with the dish machine. The DON communicated the dish machine temperature should at minimum

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F 812	Continued From page 17 be 120 degrees Fahrenheit before dishes were ran and if the temperature was not 120 degrees Fahrenheit, then the dish machine should be ran until a temperature of 120 degrees Fahrenheit was reached. If there were any issues with the dish machine the DON stated that the Dietary Manager would notify the Administrator and a ticket would be placed for repair. The DON explained she was unaware of the service reports due to the reports being received by the Administrator. An interview with the Administrator could not be conducted at the time during the survey as the Administrator was unavailable for the week.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		5/12/23

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F 867	Continued From page 18	F 867		

not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to

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F 867	Continued From page 19	F 867		

ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)

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	345331	A. BUILDING _____ B. WING _____	C 04/14/2023

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F 867	Continued From page 20 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey completed on 7/09/2021 and the complaint survey conducted on 4/22/22. The failure was for two deficiencies that were originally cited in the areas of Dietary Services (F812) and Resident Rights/Exercise of Rights (F550) and were subsequently cited again during the current annual recertification survey on 4/14/2023. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referenced to F812 - Based on observations, vendor interview, staff interviews, and record review, the facility failed to sanitize dishware for meal service by failing to ensure the wash and final rinse cycles of	F 867	F867 The facility maintains Quality Assessment and Assurance Committee (QAPI) with members including the Administrator, Director of Nursing, Medical Director, Infection Preventionist, and at least three additional staff from nursing and/or Interdisciplinary team. On 5/8/23 a special communication was provided to the QAPI Committee. This included the survey results and the Plan of Correction defining the training and monitoring. Further follow-up discussion will be included on the agenda of the next scheduled QAPI Committee meeting, which takes place on 5/26/23. On 5/8/23, through this special communication, the QAPI members were trained by the Administrator on the expectations for sustaining an effective Quality Assurance Program. Corrective Action: F550	

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F 867	Continued From page 21 the low temperature dish machine operated at accurate temperatures for 2 of 2 observations. This practice had the potential to affect food served to all residents. During the recertification survey conducted on 7/9/21 the facility failed to serve potentially hazardous foods (sliced strawberries, sliced melon, and cottage cheese) at 41 degrees Fahrenheit (F) or below to 4 of 4 residents and failed to label and date foods in the freezer in 1 of 2 nourishment rooms. F550 -Based on observations, record review and staff interviews, the facility failed to maintain dignity for 1 of 3 residents with an uncovered urine collection bag for public view. (Resident # 44) The reasonable person concept was applied to this deficiency as individuals have the expectation of being treated with dignity and would not want their urine visible to visitors, staff and other residents. During the complaint investigation conducted on 4/22/22 the facility failed to maintain a resident's dignity by delaying incontinence care for 1 of 3 residents reviewed for dignity. During an interview on 04/14/23 at 04:23 PM with the Director of Nursing (DON) she believed the breakdown in the system related to F812 was an isolated incident. DON explained the breakdown in the system related to F550 was due to oversight. DON stated during QAA meetings, when there is an issue a plan will be put into place for auditing. DON verbalized QAA would meet monthly and discuss any issues and/or audits that were in place.	F 867	On 4/14/23, the Director of Nursing was made aware that Resident #44 did not consistently have a privacy cover on his catheter bag. The Director of Nursing addressed the issue with staff and corrected the deficient practice for this resident. By 5/12/23 all nursing staff will be in-serviced by the Director of Nursing or designee to ensure residents' catheter bags have a privacy cover in place. Any nursing staff members who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 5/8/23 the process for covering catheter bags will change to ensure all catheter bags have a privacy cover in place. We will be using new catheter bags that include a built-in privacy cover. The new catheter bag with built-in privacy cover will be put in place at each resident's next scheduled catheter change, per physician orders. Beginning 5/8/23, the Nurse Supervisor or designee will conduct three observations a week for 12 weeks to ensure privacy covers are in place covering catheter bags. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at	

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F 867	Continued From page 22	F 867	which time frequency of monitoring will be determined by the QAPI Committee. Corrective Action: F812 A bad fuse was discovered in the hot water heater that supplies the hot water to the dish machine. This fuse was replaced on 5/3/23 and is now providing appropriately hot water to the dish machine to meet temperature requirements. By 5/12/23 all dietary staff will be in-serviced by the Dietary Manager to ensure staff know the required minimum temperature for the wash and rinse cycle; and that staff know to re-check the temperature gauge in the middle of the wash and rinse cycle to ensure the temperatures remain compliant. Any staff members who do not receive the training by 5/12/23 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. The Administrator and Plant Operations Manager will be added to the dish machine vendor's monthly service report. This report includes a test of the water temperature. If the water temperatures are not within regulatory requirements, the Plant Operations Manager will initiate a work order to investigate and make any necessary repairs.	

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F 867	Continued From page 23	F 867	Beginning 5/8/23, the Plant Operations Technician and/or designee will audit the dish machine water temperature three times per week for 12 weeks to ensure the wash and rinse cycle of the low temperature dish machine operates at accurate temperatures. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Plan of Correction Date 5/12/23.	