STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345319	A. BUILDING _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

(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 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/26/23 through 06/30/23. Event ID# LZXE11. The following intakes were investigated: NC00196309, NC00192586, and NC00191715. 3 of 9 complaint allegations resulted in deficiency.	F 000		
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 observations, record review, resident interview, and staff interviews the facility failed to assess the ability of a resident to self-administer medications that were kept at bedside for 1 of 1 sampled resident reviewed for self -administration of medications (Resident #28). Resident #28 was admitted to the facility on 10/8/21 with diagnoses inclusive of dementia and dysphagia. A revised care plan dated 3/21/23 revealed Resident #28 was not care planned to self-administer medications. A quarterly Minimum Data Set dated 6/9/23 indicated Resident #28 had moderate cognitive impairment. A review of the physician orders on 6/19/23 indicated Resident #28 had daytime medication orders by mouth for pain (acetaminophen),	F 554	F554 Resident Self Administer Meds-Clinically Appropriate The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	7/20/23

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

Electronically Signed | 07/17/2023

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F 554	Continued From page 1 vitamin B-12 deficiency, endocrine (levothyroxine sodium) blood thinner (apixaban), heart burn (famotidine), edema (furosemide), gastrointestinal therapy (omeprazole), allergies (fexofenadine), cardiovascular therapy (dofetilide), and vitamin D deficiency (cholecalciferol) and did not indicate an order for self-administration of medications by mouth. A review of the electronic medical record on 6/19/23 (assessments) revealed there was no self-administration assessment completed for Resident #28. During an observation and interview on 6/19/23 at 11:18 AM Nurse #1 entered Resident #28's room and placed a small cup of medications in pill form at bedside before exiting the room. Resident #28 was observed self-administering the cup of medications with water. When asked if it was normal practice for the nurse to deliver the medication for self-administration, Resident #28 stated Nurse #1 was usually in the area outside of her room and that she was fine self-administering her medication. During an interview on 6/20/23 at 4:05 PM Nurse #1 revealed she usually provided Resident #28 with her cup of medications and remained in the area outside of her room while Resident #28 self-administers her medications. She further revealed she did not watch Resident #28 take her medications after she brought the medications into the room and placed them at bedside for the resident to self-administer. During an interview on 6/21/23 at 3:30 PM the Director of Nursing (DON) indicated she expected nursing staff to watch residents (who did not have	F 554	No harm was caused to Resident #28 when she self-administered her medications on 6/19/23. The resident did not have any issues with the med pass. Nurse #1 was re-educated by the Director of Nursing on 6/26/23 on the requirement to observe residents (who do not have an order to self-administer medications to ensure the medications were taken safely and as ordered. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All Licensed Nurse and Medication Aides (full time, part time, and contract including agency staff) were re-educated by the Director of Nursing on the requirement to observe residents (who do not have an order to self-administer medications and a completed assessment to safely administer their own medications) to ensure the medications were taken safely and as ordered. Any Licensed Nurses or Medication Aides that did not receive the education by 07/20/23 will not be allowed to work until they receive the education.	

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F 554	Continued From page 2 an order for self-administration of medications) take their medications to assure that no medications dropped on the floor or assure no choking incidents occurred. She further indicated Resident #28 did not have an order or assessment to self-administer medications and shouldn't self-administer due to diagnoses of dementia and dysphagia. During an interview on 6/22/23 at 2:25 PM the Administrator indicated she expected Nurse #1 to observe the Resident take and swallow medication. She further indicated the practice of watching resident take and swallow their medications was part of nursing training.	F 554	Newly hired Licensed Nurses and Medication Aides and agency staff will be educated on the requirements for residents to self-administer medications during their orientation. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing, Assistant Director of Nursing or designee will observe the medication administration for 5 residents weekly for 4 weeks and then 5 residents monthly for 2 months to ensure the Nurse observes the resident taking their medications as ordered (unless the resident has been assessed and has an order to self-administer their medications). Audit results will be documented on the audit tool titled Safe Medication Administration. Results will be reviewed and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group,	F 565		7/20/23

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F 565	Continued From page 3 to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and staff interviews the facility failed to resolve group grievances that were brought to resident council meetings for 4 of 8 months (February, March, April, and May 2023). The findings included:	F 565	F565 Resident/Family Group and Response The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and	

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F 565	Continued From page 4 A review of the Grievance Policy dated 9/22/20 (also known as the Suggestion/ Complaint System) revealed complaints were reviewed by the Department Manager, who provides a resolution to the complaint or develops a "plan of action" for resolution of the complaint within 3 business days from the date of the complaint. A review of Resident Council meeting minutes from August 2022 through November 2022 and February 2023 through May 2023 was completed. February 2023 through May 2023 meeting minutes had concerns related to the following: -(2/14/23 meeting minutes/new business) Residents not receiving showers 2 times per week. -(3/14/23 meeting minutes/ new business) Clothes and socks missing/ not being returned from laundry; (old business) Residents not receiving showers 2 times weekly was not resolved or addressed. -(4/11/23 meeting minutes/ old business) Residents not receiving showers twice a week was not resolved or addressed; Clothes and socks missing/ not being returned from laundry was not resolved or addressed. (new business) Resident wandering into other resident rooms was getting worse. -(5/24/23 meeting minutes/ old business) Residents laundry still not returning clothing and socks a big problem was not resolved or addressed. Showers were not being given twice a week and a lot of times not given for a week, was not resolved, or addressed. Wandering residents continue entering other resident rooms was not	F 565	federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The concerns voiced during resident council on 2/14/23, 3/14/23, 4/11/23 and 5/24/23 regarding residents not receiving showers two times per week were addressed by the Director of Nursing after each council meeting and an audit and a QUAPI was done in 2/23, 3/23, 4/23, 5/23, and 6/23 and was on going. There was documented improvement, but the issue was not resolved. The QA committee was still working to resolve the concerns. The concerns voiced during resident council on 3/14/23, 4/11/23 and 5/24/23 regarding clothing and socks missing/not be returned from laundry was addressed by the Administrator to the resident council chair after each council meeting. The facility provided 30 dozen new pairs of socks to the residents to replace any that were missing in 4/23. There were many socks in the laundry room that were not sorted. The administrator, director of nursing and social worker met weekly and	

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F 565	Continued From page 5 resolved. During interviews with Residents #34, #20, #55, #6 who attended the Resident Council meeting on 6/20/23 at 2:00 PM revealed the occurrence of missing clothing and socks was on-going and no resolution had been offered to the Resident Council group. Two of 9 residents who attended the Resident Council meeting stated they did not receive 2 showers as recent as one week ago and the concern had not been resolved. They further revealed the concern had been voiced during resident council meetings and nothing seemed to change. During an interview on 6/20/23 at 4:40 PM the Activities Director indicated after she records the Resident Council meeting minute concerns, she provides the department heads with a copy and follows up with the Director of Nursing (DON) or the Administrator for a status or resolution. She further indicated missing clothing items were handled by the Social Worker (SW). During an interview on 6/21/23 at 1:10 PM the SW revealed she handled grievances related to missing clothing and that she and other staff look for missing clothing in the laundry room and resident closets until the search is exhausted. She further revealed she provided families and residents with a black marker to label clothing during the admission process. However, the label may wear off after multiple washes in the laundry. She stated that she was not currently searching for any missing items and that she had exhausted the search. During an interview on 6/21/23 at 2:59 PM the DON revealed she looked for missing items and	F 565	sorted and matched the socks in laundry. Several of the clothing items were not reported missing using the complaint form. Notes were left in the laundry room. On 7/12/23 the facility and the laundry provider have agreed to purchase a clothing press that permanently labels the clothing. The concerns voiced during resident council on 4/11/23 and 5/24/23 regarding residents wandering into other resident□s rooms was addressed by the Administrator on 6/23/23. Resident # is no longer able to wander due to medical conditions and resident # had a medication review with medication changes. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The Administrator completed an audit on 6/26/23 of all resident council minutes from February 2023 through July 2023 to ensure all voiced concerns had been addressed. After reviewing the minutes, Administrator met with council chair on 7/6/23 to discuss any concerns that had not been addressed. Chair council reported there were no other issues or concerns that were not being addressed. On 6/29/23, a new form was developed and facility began using for the resident council agenda, attendance, and taking minutes and has a place to	

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F 565	Continued From page 6	F 565		

was unsuccessful with locating those items. She further stated the facility did not normally replace missing items and that the facility could not resolve the missing clothing issue. The DON indicated the concerns regarding residents not receiving 2 showers per week was brought to the Quality Assurance (QA) group in February 2023 and the goal was to implement a shower team instead of the current practice of each nurse aide providing 2-3 showers during their shift.

However, a shower team was not implemented due to budget restrictions. She believed the 2 shower per week concern had not been resolved. She further indicated wandering residents were redirected from other resident rooms and Velcro stop guards were placed across the doorway on some resident rooms. However, they were in the process of ordering additional stop guards and was not aware that residents were still complaining of wandering residents.

During an interview on 6/21/23 at 5:25 PM Nurse Aide #1 indicated missing clothing concerns increased when laundry staff changes took place a few months ago.

During continuous observation of the laundry room on 6/22/23 at 11:59 AM multiple piles of unclaimed clothing items were in multiple bins, drawers, and shelves.

During an interview on 6/22/23 at 12:05 PM the Laundry Attendant revealed missing clothing concerns had worsened in the past 6 months. She further revealed she often tried to match socks and invite families to look through their lost and found to find missing items. After 30 days of unclaimed missing items in the laundry room,

document the plan to resolve any concerns or issues. The administrator will complete the plan and resolution and it will be presented back to the council.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The grievance policy was reviewed by the Administrator and Quality Assurance Committee on 6/27/23.
On 6/29/23, a new form was developed and facility began using for the resident council agenda, attendance, and taking minutes and has a place to document the plan to resolve any concerns or issues. This form will be submitted to administrator within 5 business days after council meeting. The administrator will complete the plan and resolution and it will be presented back to the council before next council meeting.

All department managers including the Director of Nursing, Assistant Director of Nursing, Social Worker, Business Office Manager, Activities Director, Dietary Manager, Therapy Director, Maintenance, and Housekeeping Supervisor, nursing assistants were re-educated by the Administrator on the procedure and time frame for resolving grievances voiced in resident council and communicating the resolution to the resident council on 6/30/23.

- 4 Indicate how the facility plans to

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F 565	Continued From page 7 those items are taken to the Administrator and sometimes donated or discarded. She stated that a better labeling system could possibly decrease the incidents of missing clothing. During an interview on 6/22/23 at 3:00 PM the Administrator indicated the facility addressed the concerns related to showers through QA meetings from January 2023 through April 2023 and felt there were improvements in residents getting 2 showers per week, based on shower sheets, not Resident Council's continued concerns. Regarding the missing clothing concerns from Resident Council members, the Administrator revealed residents and families were encouraged to look through the lost and found which housed clothing with missing labels. She further revealed the facility re-evaluated wandering this week and was making plans to transfer a particular resident to a memory care unit that would provide enhanced care.	F 565	monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Administrator or designee will audit resident council minutes monthly for 3 months to ensure all grievances and concerns voiced are addressed according to the grievance policy. Any repeated concerns will be investigated further by the Administrator to ensure timely resolution. Audit results will be documented on the audit tool titled Resident Council Concerns and Response. Results will be reviewed and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		7/20/23

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F 584	Continued From page 8 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews, and staff interviews the facility failed to maintain a hand sink in working order and provide clean bed linens for 2 of 2 residents (Resident #6 and Resident #33) on the 200 Hall reviewed for homelike environment. The findings included: 1. Resident #6 was admitted to the facility on 12/6/22 and had a quarterly Minimum Data Set	F 584	F584 Safe/Clean/Comfortable/Homelike Environment The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will	

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F 584	Continued From page 9 assessment dated 6/8/23 that indicated an intact cognition. An interview and observation on 6/19/23 at 4:36 PM with Resident #6 revealed there had been no cold-water from her faucet (room #214) since she was admitted to the room in December 2022 and that she informed the Maintenance Manager who promised her a new sink. She further revealed she used the sink regularly to maintain her hygiene. During observation, the Surveyor turned the handle for cold-water faucet and there was no running cold-water. An interview on 6/20/23 at 4:10 PM Nurse #1 indicated she reported the "no cold water" issue in room 214 to the Maintenance Manager on one occasion about 2-3 months ago, when she attempted to get cold water for the resident in bed #1. She further indicated she did not follow up with the Maintenance Manager when the faucet was not repaired. An interview on 6/21/23 at 2:25 PM the Maintenance Manager revealed he did not have a process for completing maintenance requests and orders. He further revealed he was made aware of facility maintenance repair needs and was unaware there was no cold-water in the sink of room 214 until 6/20/23, after the Surveyor was made aware and reported it to the staff nurse. He stated he then restored the cold-water faucet on the morning of 6/20/23. During an interview on 6/21/23 at 3:46 PM Nurse Aide #2 indicated she did not notice that room 214 had no running cold water and that she normally used the hot water side faucet when she used the sink. She further indicated she could not	F 584	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The cold water faucet on the hand sink in room #214 was repaired on 6/20/23, by maintenance. It was turned off under the cabinet. Resident #33 and resident #6 was provided with clean linens for their bed on 6/20/23. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The Maintenance Director completed an audit 6/23/23 of all sinks to ensure both the hot and cold water were working properly. There were no other sinks with the water turned off. The Director of Nursing, Laundry Supervisor audited bed linens on current residents□ beds on 6/26/23 to ensure each resident had clean bed linens. There were no other beds identified with dirty	

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F 584	Continued From page 10	F 584		

recall if Resident #33 told her in the past.

An interview on 6/21/23 at 2:30 PM the Director of Nursing (DON) indicated she was not aware that there was no running cold-water in room 214. Her expectation was for all residents to have hot and cold running water in their bedroom/bathroom sinks.

2. Resident #33 was admitted to the facility on 10/20/2017.

On 6/19/23 at 12:05 PM an observation revealed Resident #33 in bed and lying on the bed sheet that displayed three coin sized dried reddish-brown stains that were visible upon entering the room.

On 6/21/23 at 9:50 AM an observation revealed Resident #33 in bed and lying on the bed sheet that displayed the same three coin sized reddish-brown stains.

An interview on 6/21/23 at 10:28 AM Nurse Aide #4 indicated when she brought breakfast into the room on 6/21/23, Resident #33's blanket was pulled up to her chest and she did not see the soiled sheet, otherwise she would have changed it.

An interview on 6/21/23 at 10:25 AM the DON revealed per the overnight nurse report, Resident #33 received a shower on the evening of 6/20/23 and her bed linens should have been changed on shower day.

During a follow-up interview on 6/21/23 at 2:35 PM the DON indicated at least 6 nurse aides and 2 nurses cared for Resident #33 since the

linen.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The process for completing maintenance request and orders was reviewed by the Administrator and Maintenance Director on 6/30/23. Work orders will be located at the nurses station and available for any staff member to fill one out. Completed work order forms will be placed in maintenance box outside his office and copy sent to administrator. When work order is complete, maintenance will sign and submit completed work order to administrator. Administrator will document and monitor work orders for completion and timeliness.

All staff on 06/30/23 (full time, part time, and contract) were educated by the Administrator on the procedure for communicating the need for maintenance repairs and work orders. Any staff that did not receive the education by 7/5/23 will not be allowed to work until they receive the education. Education will be provided in orientation for all new hires.

All Licensed Nurses and Nurse Aides on 06/26/23 (full time, part time, and contract) were re-educated by the Director of Nursing on the schedule for changing bed linens and the requirement to change bed linens as needed if they become soiled to ensure residents maintain clean

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F 584	Continued From page 11 morning of 6/19/23 and her expectation was for her soiled bed linen to be changed once identified during care or on shower days. She further indicated she was unable to get in contact with the staff person who worked overnight and was responsible for changing the bed linens on the resident's shower day.	F 584	linens on their beds. Any Licensed Nurses or Nurse Aides that did not receive the education by 7/5/23 will not be allowed to work until they receive the education. Education will be provided in orientation for all newly hired Licensed Nurses and Nurse Aides and contract staff. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Maintenance Director will audit 5 sinks a week for 4 weeks and then 5 sinks a month for 2 months to ensure to ensure all sinks have both cold and hot water. Audit results will be documented on the audit tool titled Sink Audits. The Director of Nursing or designee will audit 5 beds a week for 4 weeks and then 5 beds a month for 2 months to ensure residents have clean linens on their beds. Audit results will be documented on the audit tool titled Bed Linens Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		7/20/23

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F 677	Continued From page 12 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with resident and staff, the facility failed to provide shaving assistance to 1 of 5 dependent residents reviewed for activities of daily living (Resident #7). Findings included: Resident #7 was admitted to the facility on 03/02/17 with diagnoses that included diabetes, respiratory failure, and chronic obstructive pulmonary disease (difficulty breathing). A review of Resident #7's Activities of Daily Living (ADL) care plan, last revised 02/17/23, revealed she needed help with ADL due to debility, weakness, and shortness of breath. Interventions included for staff to provide extensive assistance with personal hygiene and bathing. The quarterly Minimum Data Set (MDS) assessment dated 05/13/23 revealed Resident #7 had moderate impairment in cognition and displayed no rejection of care. The MDS also revealed she required limited assistance of one staff member with personal hygiene and total assistance of one staff member with bathing. During an observation and interview on 06/20/23 at 8:36 AM, Resident #7 was lying in bed with the head of bed slightly elevated. Resident #7 was	F 677	F677 ADL Care The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #7 received assistance with shaving her chin and lip area on 6/22/23 from the Assistant Director of Nursing. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The Director of Nursing	

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F 677	Continued From page 13	F 677		

observed to have several hairs on the right side of her chin and corner of the lip that were approximately ¼ to ½ inches long and gray in color. Resident #7 stated she didn't like having hair on her chin or lip and would like them removed but was unable to do it herself.

Observation of Resident #7 on 06/22/23 at 8:37 AM revealed she still had several hairs on the right side of her chin and corner of her lip that were approximately ¼ to ½ inches long and gray in color.

During an observation and interview on 06/22/23 at 10:02 AM, the Assistant Director of Nursing (ADON) stated Resident #7 had several hairs on the right side of her chin and corner of her lip that were visible to her when standing at the foot of Resident #7's bed. The ADON stated she would have expected for staff to have offered and assisted Resident #7 with a shave when providing her care or bed bath.

An observation and interview on 06/22/23 at 2:22 PM, Resident #7 still had several hairs on the right side of her chin and corner of her lip that were approximately ¼ to ½ inches long and gray in color. Resident #7 stated she received her bed baths as scheduled but no one had offered to assist her with a shave.

An unsuccessful telephone attempt was made on 06/22/23 at 12:57 PM for an interview with Nurse Aide (NA) #5 who was assigned to provide Resident #7's care on 06/20/23, Resident #7's scheduled bath day, during the 7:00 AM to 3:00 PM shift.

During an interview on 06/22/23 at 1:10 PM, NA

completed an audit of all current residents on 6/23/23, to ensure residents had received assistance with their shaving needs. No other residents were identified in the audit.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

All Licensed Nurses and Nurse Aides (full time, part time, and contract including agency) were re-educated by the Director of Nursing on assisting residents with their shaving needs when they receive a bath and as needed. Any Licensed Nurses or Nurse Aides that did not receive the education by 6/30/23 will not be allowed to work until they receive the education. Newly hired Licensed Nurses and Nurse Aides and agency staff will be educated on assisting residents with their shaving needs during their orientation.

- 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

The Director of Nursing or designee will observe 5 residents weekly for 4 weeks and then 5 residents monthly for 2 months to residents are receiving assistance with their shaving needs. Audit results will be documented on the audit tool titled Shaving Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance improvement

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F 677	Continued From page 14 #1 revealed he was assigned to provide resident showers on 06/20/23 but someone else had filled in that day because he had taken a resident out for an appointment and didn't return until late in the afternoon. NA #1 explained shaving was part of the bathing activity and when he noticed a resident with visible chin hairs, he offered to assist them with a shave. NA #1 stated it embarrassed Resident #7 to have chin hairs and she would not refuse whenever staff offered to assist her with shaving. A joint interview was conducted with the Director of Nursing (DON) and Administrator on 06/22/23 at 10:48 AM. The Administrator stated she would have expected for staff to have offered and assisted Resident #7 with a shave to remove the hairs from her chin and lip. The Administrator further stated shaving was something that should be done when providing bathing assistance and as needed.	F 677	Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as	F 803		7/20/23

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F 803	Continued From page 15 input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review, the facility failed to serve capri vegetables in a four-ounce portion per the menu. This failure had the potential to affect 34 residents with diet orders for regular diet texture and 22 residents with diet orders for mechanical soft diet texture. The findings included: A continuous observation of the lunch meal tray line on 6/19/23 from 12:08 to 12:30 PM, revealed capri vegetables (carrots, green beans, yellow squash, and zucchini) were available to serve. The Therapeutic Cycle Menu recorded residents were to receive a 4-ounce portion of vegetables. During the continuous observation, cook #1 was observed to serve capri vegetables to residents from a commercial grade stainless steel slotted spoon (a spoon with holes for drainage). At the request of the surveyor, the Certified Dietary Manager (CDM) placed a serving of the capri vegetables from the slotted spoon into a 4-ounce serving utensil. The 4-ounce serving utensil was	F 803	F803 Menus Meet Residents Needs/Prep in Adv/Followed The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Cook #1 was educated by the Certified Dietary Manager on 6/20/23 on using the	

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F 803	Continued From page 16 observed approximately ¾ full. A serving of capri vegetables from the slotted spoon did not yield a 4-ounce portion. Cook #1 was interviewed on 6/21/23 at 1:23 PM. She stated that it was her practice to serve vegetables to residents from a slotted spoon so the juice from the vegetables could drain through the holes in the spoon. Cook #1 stated that she did not realize that the slotted spoon did not provide residents with a 4-ounce portion of vegetables. The CDM stated on 6/21/23 at 1:26 PM that he did not realize that the portion of vegetables cook #1 served to residents was not a 4-ounce portion. He stated that the correct serving utensil should be used so that residents received the correct portion. A phone interview with the Registered Dietitian (RD) occurred on 6/22/23 at 10:59 AM. The RD stated she visited the facility twice per month and provided clinical support. The RD stated that in addition to the clinical support, she also completed monthly kitchen sanitation audits and test tray audits as time permitted. The RD stated that during the kitchen sanitation audits, she had not observed concerns with portions of foods served to residents. She stated, "It makes sense that a slotted spoon would not give a 4-ounce portion, but the water from the vegetables could be drained before the vegetables are put in the pan." The Administrator stated in an interview on 6/22/23 at 3:06 PM that the RD provided a full report of the monthly sanitation audit she completed, and that the Administrator was aware	F 803	correct serving utensils to ensure residents receive the correct portion size according to the menus. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The Certified Dietary Manager completed an audit of all serving utensils on 6/23/23 to ensure the facility had the correct size serving utensils available to provide the correct portions to residents according to the menus. The audit did not identify any issues with any other serving utensils. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All Dietary staff (full time, part time, and contract) were re-educated by the Certified Dietary Manager on using the correct serving utensils to provide the correct portion size according to the menus. Any Dietary staff that did not receive the education by 6/26/23 will not be allowed to work until they receive the education. Newly hired Dietary staff will be educated on using the correct serving utensils to provide the correct portion size during their orientation. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates	

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F 803	Continued From page 17 of some concerns in the kitchen previously identified by the RD. The Administrator stated any concerns identified by the RD were reviewed and discussed in monthly Quality Assurance meetings. The Administrator stated that residents should receive the portion of food according to the menu spreadsheet and that dietary staff would need some re-education.	F 803	when corrective action will be completed. The Certified Dietary Manager or designee will observe the meal tray line for 5 meals weekly for 4 weeks and then 5 meals monthly for 2 months to ensure the correct serving utensils are used to provide the correct portions. Audit results will be documented on the audit tool titled Serving Utensils and Portion Size Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation, staff interviews and record review the facility failed to provide capri vegetables (carrots, yellow squash, green beans, and zucchini) in a consistency required for residents with diet orders for a pureed diet texture. This failure had the potential to affect 12 of 74 residents with diet orders for a pureed diet texture. The findings included:	F 805	F805 Food in Form to Meet Individual Needs The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	7/20/23

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F 805	Continued From page 18 A review of the Diet Order Report revealed 12 residents with diet orders for a pureed diet texture. Review of the menus revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a pureed diet texture. The NDD recorded a dysphagia pureed diet required all foods pureed and thickened, if necessary, to a pudding-like consistency, lump free, requiring little to no chewing. A continuous observation of the lunch meal tray line on 6/19/23 from 12:08 - 12:38 PM revealed capri vegetables served to residents with diet orders for a pureed diet texture. The capri vegetables were plated by cook #1 and observed with a thin consistency that poured from the serving utensil. Cook #1 was interviewed on 6/21/23 at 1:23 PM. She stated that she did not use a recipe when she prepared pureed foods, she stated "I have been doing it so long, I add bread for fiber and that thickens the vegetables some." The Certified Dietary Manager (CDM) stated in an interview on 6/21/23 at 1:26 PM that "We don't use a recipe when we make pureed foods, but we can start." The CDM stated that the dietary staff previously served pureed foods with a thicker consistency, but the residents complained and stated, "so we thinned it out some, I guess we have gotten too thin." He stated, "you think everybody knows what they are doing, but I guess we need more training." An interview with the Rehab Manager occurred	F 805	regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Cook #1 was educated by the Speech Therapist on 6/23/23 on how to prepare and serve pureed foods at the correct thickened consistency. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents with orders for a pureed diet have the potential to be affected. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All Dietary staff full time, part time were re-educated on 7/10/23 by the Dietitian on how to prepare and serve pureed foods at the correct thickened consistency. Any Dietary staff that did not receive the education by 7/12/23 will not be allowed to work until they receive the education. Newly hired Dietary staff will be educated on how to prepare and serve pureed	

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F 805	Continued From page 19 on 6/19/23 at 1:19 PM. She stated the speech therapist (ST) left for the day and would return tomorrow. The Rehab Manager stated that she went into the kitchen and observed the pureed vegetables available on the tray line. The Rehab Manager stated, "you are right, the pureed vegetables pour from the utensil, but the speech therapist would be the expert on the consistency." The ST was interviewed on 6/20/23 at 12:23 PM. During the interview, she stated that she was the ST in the facility since October 2021 and occasionally saw pureed foods that were served to residents too thin. The ST stated when that occurred, she sent the pureed food back to the kitchen and requested the food be thickened or provide the resident with a substitute. The ST stated she also used it as an opportunity to educate dietary staff but that there may have been changes in dietary staff that caused this to reoccur at times. The ST stated the facility followed the instructions from the NDD which required pureed foods to be smooth, without texture, no lumps or food pieces and of a pudding/mashed potato consistency. The ST stated, "pureed foods should not pour from the utensil, that would be too thin." A phone interview with the Registered Dietitian (RD) occurred on 6/22/23 at 10:59 AM. The RD stated she visited the facility twice per month and provided clinical support. The RD stated that in addition to the clinical support, she also completed monthly kitchen sanitation audits and test tray audits as time permitted. The RD stated that during the kitchen sanitation audits, she had not noted the pureed foods too thin, she stated "that's something the speech therapist monitors for." The RD stated dietary staff would require	F 805	foods at the correct thickened consistency. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Certified Dietary Manager or designee will observe 5 resident plates with pureed foods weekly for 4 weeks and then 5 resident plates with pureed foods monthly for 2 months to ensure the food is prepared and served at the correct thickened consistency. Audit results will be documented on the audit tool titled Pureed Foods Audit. Results will be reviewed and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	

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F 805	Continued From page 20 education to ensure the correct consistency for pureed foods was served to residents. The Administrator stated in an interview on 6/22/23 at 3:06 PM that the RD provided a full report of the monthly sanitation audit she completed, and that the Administrator was aware of some concerns in the kitchen previously identified by the RD. The Administrator stated any concerns identified by the RD were reviewed and discussed in monthly Quality Assurance meetings. She stated we need to provide some re-education to dietary staff to make sure residents receive foods in the correct consistency.	F 805		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		7/20/23

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F 812	Continued From page 21 by: Based on observations, interviews and record review, the facility failed to wash dishes per manufacture recommendations, sanitize dishes in a chlorine solution of 50 - 100 parts per million (ppm), sanitize dishes in a quaternary solution of at least 150 ppm, perform hand hygiene between soiled and clean tasks, remove foods stored past manufacturer use-by-date, maintain cold foods in refrigeration at least 41 degrees Fahrenheit (F), restrain hair during meal prep/cleaning, store an ice scoop to drain, and cover foods during meal delivery. This failure had the potential to affect the food served to 74 of 74 residents. The findings included: a. On 6/19/23 at 11:01 AM, the Certified Dietary Manager (CDM) placed a rack of cups in the low temperature dish machine to wash. The wash cycle temperature gauge registered 100 degrees F; the rinse cycle temperature gauge registered 118 degrees F. The manufacturer instructions posted on the low temperature dish machine recorded the following: - Wash cycle temperature - minimum 120 degrees, recommended 140 degrees - Final rinse cycle temperature - minimum 120 degrees, recommended 140 degrees During the observation, the CDM used a chlorine test strip to check the chlorine concentration and the test strip registered 50 ppm. The CDM stated that he monitored the chlorine concentration at least once per shift and ensured that it was 50 ppm, but that he did not always check the temperatures of the wash/rinse cycles. The low temperature dish machine was observed	F 812	F812 Food Procurement, Store/Prepare/Serve- Sanitary The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. The Dietary Manager was re-educated by the Administrator on 6/26/23 on following the manufacturer□s guidelines for ensuring the dish machine wash cycle temperature is at minimum 120 degrees, recommended 140 degrees and the final rinse temperature is at minimum 120 degrees and, recommended 140 degrees. Dietary Aide #3 was re-educated by the Certified Dietary Manager on 6/26/23 on how to test the chlorine concentration of the low temp dish machine to ensure concentration is between 50-100 ppm.	

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F 812	Continued From page 22 in use on 6/21/23 at 1:20 PM when Dietary Aide (DA) #3 washed a rack of plates. The wash cycle temperature was 120 degrees F, the rinse cycle temperature was 130 degrees F. DA #3 stated he checked the concentration of chlorine "periodically, usually after I wash the lunch dishes," but that he had not checked the concentration yet. At the request of the surveyor, DA #3 checked the chlorine concentration with a chlorine test strip that registered between 150 - 200 ppm. DA#3 stated he was not sure what the concentration of chlorine should be. The CDM stated in an interview on 6/19/23 at 1:26 PM that the chlorine concentration for the low temperature dish machine should be between 50 - 100 ppm and that staff were trained to know that. b. An observation on 6/19/23 at 11:10 AM revealed DA #1 washed/sanitized sheet pans and stainless-steel pans in a three-compartment sink. These items were stored on the sink's counter to drain/dry. DA #1 confirmed that she set up the three-compartment sink before use and put "2 pumps" of quaternary sanitizer in the sink according to the training she received. DA #1 stated that she did not check the concentration of the quaternary sanitizer before use. At the request of the surveyor, DA #1 used a quaternary test strip to check the concentration and the result was 50 ppm. DA#1 stated during the observation that the concentration of the quaternary sanitizer should be "at least 100" ppm and that the concentration was not strong enough. The CDM stated in an interview on 6/21/23 at	F 812	b. Dietary Aide #1 was re-educated by the Certified Dietary Manager on 6/23/23 on how to set up the three compartment sink to ensure the quaternary sanitizer solution registers at 200 ppm. c. Cook #1 and Dietary Aide #3 were re-educated by the Certified Dietary Manager on 6/22/23 on performing hand hygiene and changing gloves after touching non-clean surfaces and before touching food items. d. The case of one ounce packets of sour cream with a manufacturer use by date of 6/5/23 were removed from the walk-in cooler by the Certified Dietary Manager on 6/19/23 The case of preboiled eggs (3 packages of 12 eggs each) with a manufacturer use by date of 6/14/23 were removed from the walk-in cooler by the Certified Dietary Manager on 6/19/23 e. The thermometers in the reach in cooler and the walk in cooler were replaced and checked for accuracy by the Certified Dietary Manager on 6/20/23 f. Dietary Aide #1 and Dietary Aide #2 were re-educated by the Certified Dietary Manager on 6/21/23 on how to properly wear a hairnet to cover their hair. g. The ice scoop holder was hung on 6/23/23 by the Certified Dietary Manager to ensure the water could drain.	

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F 812	Continued From page 23 1:26 PM that set-up instructions used to be posted at the three-compartment sink and he was not sure why the instructions were no longer posted, but that staff were trained to ensure the quaternary sanitizer solution registered 200 ppm. c. During a continuous observation of the lunch meal tray line on 6/19/23 from 12:08 PM to 12:28 PM, Cook #1 and DA #2 were both observed to complete the following tasks without performing hand hygiene: - Cook #1, wore the same gloves to prepare foods for the lunch meal, adjusted her eyeglasses, scratched her forehead that was visibly wet from sweat, wiped her hands on a visibly soiled towel, opened a metal drawer and removed serving utensils used to serve food to residents, scraped mashed potatoes from the serving utensil into the stainless-steel pan of mashed potatoes served to residents, removed a stem from the stainless-steel pan of green beans served to residents, and moved ribs on a plate served to a resident. - DA #2 used her bare hands and reached underneath her shirt to adjust her clothing, scratched the bridge of her nose, left the tray line, and removed cups of coleslaw, which were uncovered, and served to residents; her thumb touched the coleslaw served to residents; and dropped a dinner roll onto the floor, picked up the dinner roll from the floor and discarded it in the trash. The floor was visibly soiled with water/debris. Cook #1 was interviewed on 6/21/23 at 1:23 PM and stated that she did recall that she did not change her gloves and that she did recall some of	F 812	h. The Certified Dietary Manager ordered new lids for the small bowls on 6/22/23. Until the lids arrive, food will be covered by plastic wrap. All foods will be covered before they leave the kitchen by 6/22/23. All dietary staff were in-serviced on 6/22/23 by dietary manager. Those not in attendance will be in-serviced by dietaty manager before they can begin work by 6/26/23. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. The Administrator and Certified Dietary Manager completed a thorough kitchen tour and audit on 6/23/23 to identify any additional concerns related to food procurement, storage, preparation, and serving. No other issues were identified during audit on 6/23/23. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All Dietary staff full time, part time were re-educated by the Certified Dietary Manager and the Dietitian on the following topics on 06/26/23: " Following the manufacturers guidelines for operating the low temp dish machine at the recommended temperatures. " How to test the chlorine concentration	

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the items she touched. Cook #1 stated "I was sweating on the line, so I wiped my forehead. I did not think about it at the time that I was wearing the same gloves and did not wash my hands." Cook #1 stated she was trained and knew to perform hand hygiene when her hands/gloves became soiled.

DA #2 was interviewed on 6/21/23 at 1:47 PM. During the interview, DA #2 stated that she remembered that she touched several items and picked up a piece of bread she dropped on the floor but did not wash her hands. DA #2 stated she had no reason as to why she did not wash her hands, but that she would pay more attention going forward. DA #2 stated she was trained to wash her hands.

The CDM stated in an interview on 6/21/23 at 1:26 PM that some dietary staff were employed for many years and others only a couple years. He stated, "you think everybody knows what they are doing, but I guess we need more training." The CDM stated that staff should have a habit of washing their hands.

d. The walk-in cooler was observed on 6/19/23 at 11:35 AM with foods stored past the manufacturer use-by-date:
- One case of one-ounce packets of sour cream; manufacturer use-by-date of 6/5/23.
- One case of preboiled eggs, 3 packages of 12 eggs each; manufacturer use-by-date of 6/14/23.

During the observation the CDM stated that all staff were responsible for checking the refrigeration units for out-of-date items, and stated, "but mostly me." The CDM stated he checked the refrigeration units for out-of-date

of the low temp dish machine to ensure the concentration is between 50-100 ppm.
" How to set up the three compartment sink to ensure the quaternary sanitizer solution registers at 200 ppm.
" Proper hand hygiene
" Using or discarding food items by the manufacturer□s use by date.
" Replacing the thermometers in the coolers and routinely checking for accuracy in temperature readings.
" How to properly wear a hair net to restrain all hair.
" How to store the ice scoop to ensure the water can drain.
" The process for covering all food items on the residents tray. Will use plastic wrap when lids are not available.

Any Dietary staff that did not receive the education by 6/30/23 will not be allowed to work until they receive the education. Newly hired Dietary staff will be educated on all topics listed above during their orientation.

- 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

The Administrator or designee will complete a thorough kitchen tour and audit weekly for 4 weeks and then monthly for 2 months to ensure the food is procured, stored, prepared and served as required. Audit results will be documented on the audit tool titled Kitchen Audit. Results will be reviewed

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F 812	Continued From page 25 items weekly on Fridays but missed checking recently. He stated the foods he ordered on Friday, 6/16/23 were not delivered, so he did not check refrigeration and could not explain why the sour cream was missed for two weeks. Cook #1 stated in an interview on 6/21/23 at 1:23 PM that dietary staff checked refrigeration units for out-of-date items daily, but the sour cream and pre-boiled eggs "just got by." e. On 6/19/23 at 11:25 AM the reach in cooler was observed with 25 cartons of milk, eight ounces each. Two dial refrigerator thermometers were stored inside. One thermometer registered 32 degrees F and the second one registered 36 degrees F. The panel thermometer mounted on the outside of the reach in cooler registered 43 degrees F. Cook #1 checked the temperature of two cartons of milk at the request of the surveyor. Each carton of milk was 44.4 degrees F. On 6/19/23 at 11:35 AM an observation of the walk-in cooler, revealed a dial refrigerator thermometer that did not register a temperature. The CDM stated, "it is not registering a temperature." During the observations, the CDM stated that he did not check the thermometers stored in the refrigeration units for accuracy, but just replaced them about every six months. He stated the thermometers in the reach in cooler were last replaced in December 2022. He could not recall when he last placed a thermometer in the walk-in cooler. f. A continuous observation occurred on 6/19/23 from 11:10 AM until 11:23 AM. DA #1 and DA #2	F 812	and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance and will be completed by 07/20/2023.	

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both performed the following tasks while their hairnets only covered the crown of their head, which left hair in the front and back exposed.
- DA #1 rolled flatware in napkins that were served to residents and washed stainless steel pans and sheet pans in a three-compartment sink.
- DA #2 rolled flatware in napkins and placed dinner rolls in plastic bags that were served to residents.

DA #1 and DA #2 were interviewed on 6/19/23 at 11:36 AM. Both stated that they knew that their hair should be completely covered but that they did not realize it was not.

A second observation occurred on 6/21/23 at 1:20 PM. DA #2 was observed in the kitchen cleaning the tray line. She wore a hairnet that did not cover the front or back of her hair.

Cook #1 stated in an interview on 6/21/23 at 2:23 PM that she noticed some staff wore hair nets that did not cover their hair, and when she saw that she would remind staff to cover their hair. Cook #1 stated that she had not noticed that recently.

The CDM stated in an interview on 6/21/23 at 1:26 PM that he monitored staff to ensure they wore hair restraints, but that he had not noticed a recent concern.

g. On 6/19/23 at 11:32 AM, the ice scoop was observed stored in a pool of water inside a holder without a lid that was stored lying on its side on a meal prep table. A second observation of the same occurred on 6/21/23 at 1:25 PM.

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During the observation on 6/21/23 at 1:25 PM, the CDM stated the ice scoop holder should be hung so the water could drain to keep the ice scoop from sitting in pooled water.

h. On 6/19/23 from 12:08 PM to 12:40 PM, the lunch meal tray line was observed with small bowls of coleslaw and small bowls of fruit cocktail, all uncovered and placed on lunch meal trays for delivery to residents. The CDM placed a plastic bag over the lunch meal delivery carts that remained open at the bottom. The lunch meal trays were delivered to residents on the 100, 200 and 500 halls.

An observation on 6/19/23 from 12:40 PM to 12:50 PM, of lunch meal delivery to the 200-hall, rooms 202 - 216, revealed the cart was delivered to the 200-hall in front of room 202. Nursing staff removed the plastic cover from the lunch meal cart with meal trays that contained coleslaw and fruit cocktail that was uncovered. Nurse Aide (NA) #1 removed the lunch meal tray for Resident #17, walked to her room, identified Resident #17 was not in the room, returned to the hallway with the lunch meal tray and inquired of staff where Resident #17 was located. Nursing staff responded that Resident #17 was in the dining room. NA #1 walked with the lunch meal tray of uncovered coleslaw and fruit cocktail to the dining room and then returned to Resident #17's room. NA #1 placed the lunch meal tray in Resident #17's room while a staff member assisted Resident #17 to her room for lunch. The lunch meal cart remained in front of room 202 while nursing staff passed meal trays that contained coleslaw and fruit cocktail uncovered to residents in rooms 202 - 216. A fly was observed on the 200-hall during the observation of lunch meals

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delivered to residents.

The Rehab Manager was interviewed on 6/19/23 at 1:06 PM, and provided the following measurements at the request of the surveyor:
- From room 202 to 216, approximately 108 feet
- From Resident #17's room to the dining room approximately 109 feet

An observation of two small flying insects occurred on 6/20/23 at 1:53 PM at the nurse's station.

A second observation of the lunch meal delivery on the 200-hall occurred on 6/22/23 from 12:30 PM to 12:40 PM. Ambrosia salad was observed uncovered on lunch meal trays served to residents.

NA #1 was interviewed on 6/21/23 at 4:22 PM. NA #1 stated that she saw that some foods were uncovered on the lunch meal trays on 6/19/23 when the meal trays came on the hall, she took a meal tray into Resident #17's room, but the Resident was not there. NA #1 stated then she realized Resident #17 was in the DR, and took the meal tray there, but then brought Resident #17 to her room to have lunch. NA #1 stated she did not realize she was carrying a meal tray with some food items uncovered for such a long distance.

The CDM stated in an interview on 6/21/23 at 1:26 PM that he was aware that dietary staff did not cover some foods served in the small bowls because he did not have the lids to fit the bowls. He stated that in the past the lids used were too difficult for nursing staff and residents to remove,

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so he instructed dietary staff to use smaller lids that covered the food, but he just needed to order more of the smaller lids. He stated there was no real reason why he had not ordered the lids. He stated the meal carts were covered before leaving the kitchen, but once the cart reached the halls nursing staff removed the cover which left some foods uncovered.

A phone interview with the Registered Dietitian (RD) occurred on 6/22/23 at 10:59 AM. The RD stated she visited the facility twice per month and provided clinical support. The RD stated that in addition to the clinical support, she also completed monthly kitchen sanitation audits and test tray audits as time permitted. The RD stated that during the kitchen sanitation audits, she identified out-of-date foods, and the ice scoop was not hung in a position to drain, but that she had not observed concerns with hand hygiene, sanitation of the dishes or food items delivered to residents uncovered.

The Administrator stated in an interview on 6/22/23 at 3:06 PM that the RD provided a full report of the monthly sanitation audit she completed, and that the Administrator was aware of some concerns in the kitchen previously identified by the RD. The Administrator stated any concerns identified by the RD were reviewed and discussed in monthly Quality Assurance (QA) meetings. The Administrator stated that hand hygiene was a standard QA topic, dietary staff were reminded to perform hand hygiene, before starting work, after going to the bathroom, after touching contaminated items like the trash, and door handles. Dietary staff were trained to remove gloves, between soiled tasks and perform hand hygiene. The Administrator stated that

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F 812	Continued From page 30 dietary staff should wear hair restraints while in the kitchen that covered the hair completely. The Administrator stated dietary staff should follow the manufacturer guidelines for sanitation, all foods, cold or hot should be maintained at correct temperatures, and the ice scoop should be in a covered container stored so that water did not collect in the bottom of the container. The Administrator stated that she also saw foods come from the kitchen uncovered that week and that she inquired of the dietary staff why that occurred, but that she was not sure why that happened. The Administrator stated all foods should be covered before leaving the kitchen. The Administrator further stated that based on the concerns identified, dietary staff would need some re-education.	F 812		