STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345163	A. BUILDING ______ B. WING ______	C 10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBRIDGE HEALTH AND REHABILTATION	211 MILTON BROWN HEIRS ROAD BOONE, NC 28607

(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 survey was conducted June 6, 2022 through June 9, 2022. The facility was found in compliance with the requirement CFR483.72 Emergency Preparedness Event ID # CECQ11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted October 2, 2023 - October 5, 2023. Survey ID # CECQ11. Intakes investigated were: NC00207447, NC00207358, NC00207343, NC00206736, NC00206458, NC00206224, NC00206226, NC00205369, NC00204061. 4 of the 25 allegations resulted in a deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		11/3/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/28/2023

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 561	Continued From page 1 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews the facility failed to provide a dependent resident with his choice of showers for 1 of 2 residents (Resident #145) reviewed for providing assistance with activities of daily living. The finding included: Resident #145 was admitted to the facility on 09/22/23 with diagnoses that included heart failure and diabetes mellitus. A review of the nursing admission assessment dated 09/22/23 revealed that Resident #145 was alert. A review of the facility's shower schedule indicated Resident #145 was scheduled to receive showers on Tuesday and Friday on evening shift. A review of Resident #145's shower/bathing record since his admission on 09/22/23 revealed documentation of morning and evening wash ups and two occasions of bed baths given. There were no showers documented for Resident #145.	F 561	Resident #145 who was identified of receiving bed bath however requested a shower immediately received a shower with therapy after it was brought to DON attention. CNAs were educated on the safest way to give residents a shower by the Therapist. Facility DON completed a facility audit to ensure all residents had received a shower or bed bath within the last 5 days on 10-05-23. Facility social worker did a survey of all residents to ensure we have their correct preferences to bed bath or shower. Unit nurse managers will complete an audit every Thursday of all residents on their unit to ensure residents received their preference of shower or bed bath two or more times a week unless refused. This audit will start 10-23-23 for 3 months. CAN’s will document their showers, bed bath, or refusals in point click care under each resident POC under “bathing task.” Education for CNAs will be completed by 10/27/23 on resident preferences and correct documentation of bathing task.	

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F 561	Continued From page 2	F 561		

Continued From page 2

During an interview and observation of Resident #145 on 10/02/23 at 2:14 PM the Resident was sitting in his wheelchair at his bedside. He was dressed in street clothes and had no body odors detected. The Resident explained that he had not had a shower since he was admitted to the facility from the assisted living facility where he previously resided. He continued to explain that he was used to getting two showers a week, which was what the staff had told him that he would receive at this facility but when he asked for his showers, he was told they would check into it.

On 10/03/23 at 11:06 AM Resident #145 was sitting on the side of his bed wearing a gown. He explained that he had not yet gotten ready for the day and still had not received or been offered a shower since he was admitted on 09/22/23.

Several attempts were made to interview NA #3 who worked on Friday 09/22/23, but the attempts were unsuccessful.

On 10/03/23 at 4:41 PM an interview was conducted with Nurse Aide (NA) #1 who worked with Resident #145 on Tuesday 09/26/23 who explained that showers were scheduled by room numbers and every room was scheduled for 2 days a week unless the resident requested more showers. NA continued to explain that he did not give Resident #145 a shower on 09/26/23 and stated he overlooked the fact that the Resident needed a shower that day.

On 10/04/23 at 2:53 PM an interview was conducted with NA#2 who worked on Friday 09/29/23, explained the residents' showers were scheduled by room numbers and the schedules

Provider's Plan of Correction (F 561):

Education will be continued during each orientation for all new staff or agency staff. Then yearly education will be provided at the facility's fair on resident choices, the importance of a shower, and documentation.

Monthly the DON will complete an audit of resident bathing and preferences for 3 months. This will then be present in the QA meetings for identification of trends, need for further education, and to determine the need for and frequency of continued monitoring for monthly compliance.

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F 561	Continued From page 3	F 561		

were kept in the notebook at the nursing station. NA continued to explain she had never given Resident #145 a shower because she had not been trained in how to give showers.

On 10/05/23 at 11:10 AM an interview was conducted with NA #4 who worked first shift with Resident #145. NA explained that the Resident was alert and oriented and voiced his wants and needs. She stated the Resident's showers were scheduled for Tuesdays and Fridays on second shift and she knew that Resident had not received a shower since he was admitted until Tuesday 10/03/23, because he reported that he had not had a shower since he had been at the facility to the therapist, and the therapist gave him a shower on that day.

An interview was conducted with the Occupational Therapist on 10/05/23 at 11:45 AM who explained that she had been providing skilled occupational therapy since his admission and stated Resident #145 informed her on 10/03/23 that he had not received a shower since he had been at the facility on 09/22/23 and she gave him a shower that afternoon on 10/03/23.

On 10/03/23 at 2:14 PM an interview was conducted with Nurse #1 who worked from 7:00 AM to 7:00 PM and who cared for Resident #145. The Nurse explained the Resident was new to the facility and he could voice his wants and needs, and he could transfer himself to the bed and wheelchair. She continued to explain that he was receiving skilled therapies since his admission. The Nurse stated if a resident refused their showers the nurse aides should report that to the nurse on duty so they could encourage the showers, but she was not aware of Resident

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F 561	Continued From page 4 #145 refusing his showers. During an interview with the Director of Nursing (DON) on 10/05/23 at 1:00 PM the DON explained the staff was waiting on skilled therapies to provide a transfer assessment on Resident #145 in order for the staff to safely transfer him. Regardless, the DON stated the Resident should have been given a shower before 10/05/23.	F 561		
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 reviews and interviews the facility failed to post cautionary and safety signs that indicated the use of oxygen for 2 of 2 residents reviewed for respiratory care (Resident #46 and #145). Findings included: 1. Resident #46 was admitted to the facility on 08/19/22 with diagnosis that included chronic obstructive pulmonary disease and respiratory failure. A review of Resident #46's physician order dated	F 695	The Facility DON placed a new sign at the entrance of the building stating "No smoking in facility oxygen is in use" on 10/5/23. This is an upgrade to our previous sign that only was a cigarette with line through it indicating "No smoking." Resident #46 and #145 received no smoking, oxygen in use signs on their door frame immediately when it was brought to the DON attention by unit manager on 10/03/23. An audit was completed by DON on	11/3/23

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F 695 Continued From page 5
05/19/23 indicated oxygen at 2 liters continuously by nasal cannula.

The quarterly Minimum Data Assessment dated 09/01/23 indicated Resident #46 was cognitively intact and used supplemental oxygen.

On 10/02/23 at 12:33 PM an observation was made of Resident #46 wearing oxygen via nasal cannula at 3 liters per minute. There was no warning sign posted on the outside of the door or door frame to indicate oxygen was in use.

A subsequent observation on 10/03/23 at 9:43 AM revealed Resident #46 wore oxygen via nasal cannula at 2 liters per minute. There was no warning sign posted on the outside of the door or door frame that indicated oxygen was in use.

An interview was conducted with Nurse #1 on 10/03/23 at 2:19 PM. The Nurse explained that it was the Unit Manager's responsibility to monitor and post the oxygen in use signage on the Resident's door who received oxygen. She indicated the Nurse's responsibility was to make sure the oxygen was delivered at the prescribed flow rate.

During an interview with Unit Manager (UM) #1 on 10/03/23 at 5:01 PM the UM verbalized she had never been told it was her responsibility to audit for oxygen signage on the residents' door that received oxygen. She stated that she did not know the facility needed to post oxygen signs because the facility did not allow smoking in the facility.

An interview was conducted with the Director of Nursing (DON) on 10/05/23 at 1:00 PM who

F 695

10/4/23 ensuring all residents who have o2 in use in their room have the red no smoking oxygen is in use sign on the resident door frame.

All nursing departments were educated on 10/27/23 reinforcing the no smoking oxygen in use signs and policy.
An audit will be completed by the unit supervisor each Thursday ensuring signage is in place for 3 months. Audit will be turned in weekly to DON and result will be reported during QA meetings.
Education will be continued during orientation for all new staff and agency staff. Then yearly education at the facility's Education fair on the sign's importance, placement, where the signs are stored and monitoring.

Monthly DON will complete a random audit to ensure signage is correct for 3 months. This will then be present in the QA meetings for identification of trends, need for further one on one education, and to determine the need for and frequency of continued audits for monthly compliance.

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explained the Unit Managers were responsible for making sure the oxygen in use signs were posted on the doors of the residents who received oxygen therapy in the mornings when they made their morning rounds.

2. Resident #145 was admitted to the facility on 09/22/23 with diagnoses that included heart failure.

A review of Resident #145's physician orders dated 09/22/23 indicated oxygen at 2 liters as needed to keep oxygen saturation greater than 90% for shortness of breath.

Resident #145's admission Minimum Data Set assessment had not been completed.

On 10/02/23 at 2:14 PM an observation was made of Resident #145 sitting in his wheelchair at his bedside wearing oxygen via nasal cannula at 2 liters per minute. There was no warning sign posted on the outside of the door or door frame to indicate oxygen was in use.

During an observation of Resident #145 on 10/03/23 at 11:06 AM the Resident was sitting on the side of his bed wearing oxygen via nasal cannula at 2 liters. There was no warning sign posted on the outside of the door or door frame to indicate oxygen was in use.

An interview was conducted with Nurse #1 on 10/03/23 at 2:19 PM. The Nurse explained that it was the Unit Manager's responsibility to monitor and post the oxygen in use signage on the Resident's door who received oxygen. She indicated the Nurse's responsibility was to make sure the oxygen was delivered at the prescribed

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F 695	Continued From page 7 flow rate. During an interview with Unit Manager (UM) #1 on 10/03/23 at 5:01 PM the UM verbalized she had never been told it was her responsibility to audit for oxygen signage on the residents' door that received oxygen. She stated that she did not know the facility needed to post oxygen signs because the facility did not allow smoking in the facility. An interview was conducted with the Director of Nursing (DON) on 10/05/23 at 1:00 PM who explained the Unit Managers were responsible for making sure the oxygen in use signs were posted on the doors of the residents who received oxygen therapy in the mornings when they made their morning rounds.	F 695		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		11/3/23

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F 761	Continued From page 8 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medications from 3 of 5 medications carts and 1 of 2 medication rooms observed for medication storage. The findings included: 1a. An observation of the 100/200 hall split medication cart was conducted on 10/03/23 at 10:58 AM along with Nurse #2. The observation revealed the following expired medications were on the cart and available for use: Aspart Insulin flex pen that was opened on 04/27/23 and Levothyroxine (used to treat thyroid issues) 88 micrograms (mcg) open bottle of 90 tablets that expired on 07/31/23. Nurse #2 was interviewed on 10/03/23 at 11:14 AM and confirmed that she was responsible for the 100/200 split medication cart. She stated that the insulin had been discontinued on 05/04/23 and just never pulled off the medication cart. Nurse #2 explained that the pharmacy had just been at the facility and gone through the medication cart and Nurse #2 thought the Unit Managers also went through the medication carts, but she could not say for sure. Nurse #2 added that she had gone through her medication cart recently "but obviously overlooked a couple	F 761	All expired medication was immediately removed from the medication cart and med room refrigerator with no negative finding by nurses on 10/05/23. On 10/05/23 DON completed an audit of medication rooms to ensure all medication is labeled correctly and not expired. Unit supervisors completed an audit on 10/05/23 ensuring all medication carts were free from expired medication. One on One education was provided with the nurses who were on the medication carts on 10/03/23 to ensure they understand the importance of auditing assigned medication cart. Education was provided by DON and completed on 10/05/23. One on One education was provided to unit supervisor on auditing unit's medication room fridge for expired medication. Education was provided by DON and completed on 10/05/2023. Staff development nurse educated all nurses on facility standard for medication storage, and labeling. Inservice completed	

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of things." She stated she would discard the expired medications.

1b. An observation of the 400-hall medication cart was conducted on 10/03/23 at 11:31 AM along with Nurse #3. The observation revealed the following expired medications were on the cart and available for use: open bottle of Milk of Magnesium that expired 09/23 and Dantrolene (muscle relaxer) 25 milligrams (mg) open bottle of 270 tablets that expired 09/20/23.

Nurse #3 was interviewed on 10/03/23 at 11:33 AM who confirmed that she was responsible for the 400-hall medication cart. She stated that she had not gone through the medication cart thus far on her shift but stated that the pharmacy came to the facility recently and went through the medication carts and the night shift nurses were also so supposed to go through the medication carts. Nurse #2 stated "if I have time, I will go through the cart, but I am not always on this cart."

1c. An observation of the 100-hall medication cart was conducted on 10/03/23 at 2:19 PM along with Nurse #4. The observation revealed the following expired medications on the cart and available for use: Geri Tussin (cough syrup) open bottle that expired 08/23, Cranberry Tablet 425 milligram (mg) open bottle that expired 08/23, and open bottle of Aspirin 81 mg that expired 08/23.

Nurse #4 was interviewed on 10/03/23 at 2:28 PM who confirmed that he was responsible for the 100-hall medication cart. He stated that he generally went through the cart once a month and had last gone through the cart at the end of August 2023. Nurse #4 stated that the night shift nurses were also supposed to go through the

F 761

by 10/27/23. Unit supervisors will begin auditing med rooms and med carts for expired medication and labeling each Thursday for 3 months. Audits will be reviewed by DON and reported at QA meeting.

Education will be continued during orientation for all new staff or agency staff. Then yearly education at the facility's fair for nurses on safety of medication storage and the facility policy and system of ensuing compliance. Nurses will be responsible for monitoring their assigned cart for expired medications, and discarding medication that is unlabeled, or expired. Central supplies employee will monitor all medication in med rooms as restocking, and responsible for discarding any medication that is not labeled or expired. Unit Supervisors will be responsible for auditing the medication room frige.

The QI committee will review the results of audit tool monthly for 3 months to determine continued frequency of monitoring, identify trends, and need for further education or disciplinary action, for continued compliance.

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medication carts once a month. He added that the expired medications should have been discarded on 09/01/23.

Unit Manager #2 was interviewed on 10/03/23 at 2:34 PM who stated that the hall nurses tried to do checks of their medication carts on a daily basis in addition to the pharmacy staff who came regularly and checked the medication carts. Unit Manager #2 stated "both day shift and night shift staff were responsible for checking the carts, but we all get busy and miss those checks." All expired medication should be pulled from the medication carts and returned to the pharmacy.

The Director of Nursing (DON) was interviewed on 10/05/23 at 4:05 PM. She stated that she expected the hall nurses to monitor their medication carts on a daily basis and pull any expired medication and return to the pharmacy or discard the medication in the medication room.

2. An observation of the 100/200 hall medication room was conducted on 10/03/23 at 2:29 PM along with Nurse #2. The observation revealed the following expired medication in the medication room and available for use: 1 bottle of Aspercreme (muscle rub) 2.7 ounces that expired 08/23 and 17 doses of Pneumococcal vaccine 0.5 milliliters that expired 08/29/23.

Nurse #2 was interviewed on 10/03/23 at 2:33 PM who stated that she would discard the expired medications at this time. She further stated that she believed that the Unit Managers were responsible for checking the medication rooms for expired medication, but she could not say for sure.

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F 761	Continued From page 11 Unit Manager #2 was interviewed on 10/03/23 at 2:34 PM who stated that the pharmacy staff visited the facility routinely and checked the medication rooms, medication carts, and temperature log. In between the pharmacy visits Unit Manager #2 stated that day shift and night shift staff were responsible for checking the medication rooms and medication carts and removing any expired medication. The Director of Nursing (DON) was interviewed on 10/05/23 at 4:05 PM who stated she expected the Unit Managers to check the medication rooms and discard any expired medication by either returning to the pharmacy or in the case of the Pneumococcal vaccine they would be placed in the sharps container.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the	F 801		11/1/23

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F 801	Continued From page 12 United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food	F 801		

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F 801	Continued From page 13 service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility failed to employ a qualified director of food and nutrition services with the competencies and skills required to carry out food and nutrition services for 88 of 88 residents. The findings included: An interview was conducted with the Dietary Manager on 10/04/23 at 12:04 PM and revealed that he had been employed by the facility for three months and was appointed the Dietary Manager position at the end of August 2023. He stated that the facility had sent him to a sister facility for three days for some training, but he had not gone through the certified dietary manager class and had no education in food and	F 801	Address how corrective action will be accomplished for those residents found to have been affected: All 88 Residents were identified as being affected. For the affected residents, the facility signed contract with Health Care Services Group on 10/11/2023 to employee qualified dietary staff when they begin services on 11/1/2023. Until that time the facility will rely on guidance and support from sister facility CDM and registered dietitian. Administrator will ensure that qualified personnel is brought in by company on 11/1/2023 start date. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 801	Continued From page 14 nutrition. The dietary manager stated that prior to working at the facility he worked in retail and again confirmed he had no educational training in food and nutrition. He added that the plan was to get him through the certified dietary manager program as well as serve safe certification but due to the staffing challenges in the dietary department he had been unable to attend either of those classes. The Registered Dietician (RD) was interviewed via phone on 10/05/23 at 8:48 AM. The RD stated that she had just started with the facility a few weeks ago and had visited the facility several times. She stated that her visits have included lots of communication with staff and providers trying to learn as much as she can about the residents and conducting their clinical review. The Administrator was interviewed on 10/05/23 at 3:59 PM and confirmed that the Dietary Manager had been in his current position since the end of August 2023 when the former Dietary Manager left the facility. She explained that shortly after the former manager left, the current Dietary Manager was appointed but then the dietary department experienced some turnover in staffing. The Administrator confirmed that the current Dietary Manager had not been trained in food and nutrition and the plan was and had always been that as soon as they were able to get enough staff to run the kitchen that the Dietary Manger would go through the required courses which for their facility was the certified dietary manager program. The Administrator stated that she had been spending time in the kitchen with the Dietary Manager but she hoped with the additional staff that they had hired they would be able to get the Dietary Manager the training he needed.	F 801	Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Facility began discussions with Health Care Services Group on 9/18/2023 to contract dietary services in facility. Contract was signed on 10/11/2023 with start date set for 11/1/2023. The contracted company is set to bring in qualified dietary staff to be in the facility immediately on the start date and will continue to keep qualified dietary staff employed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Administrator will require Health Care Services Group to provide Administrator monthly staffing reports to ensure continuity of qualified staff x 3 months. The Administrator or designee will present to QI committee will review the results of reports during monthly QA Meeting to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at quarterly QA meeting.	

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F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, record review, test tray, and resident and staff interviews the facility failed to provide palatable food that was appetizing in appearance and temperature for 4 of 6 residents reviewed with food concerns (Resident #3, Resident #8, Resident #18, and Resident #76). The findings included: 1a. Resident #3 was admitted to the facility on 01/02/23 with diagnoses that included congestive heart failure. Review of the most recent quarterly Minimum Data Set (MDS) dated 09/03/23 revealed that Resident #3 was moderately cognitively impaired and required supervision with eating. An observation and interview were conducted with Resident #3 on 10/04/23 at 2:43 PM. Resident #3 lunch tray sat in front of her with approximately 25% of the meal gone. Resident #3 stated that she had eaten what she could eat because the "chicken alfredo was cold and dry and had one small piece of chicken in it and the asparagus was also cold." She did say that she	F 804	Address how corrective action will be accomplished for those residents found to have been affected: It was found that Residents #3, #8, #18, #76 were affected by the deficient practice. Facility conducted in-service with 100% of all cooks on proper food temperatures and the new process for documenting temperatures prior to serving each meal. Facility contacted company to come to facility to assess the non-working plate warmer and make necessary repairs to ensure that food will retain proper temperature until it reaches the Resident. Facility initiated a new process on checking and documenting food temperatures on serving line prior to serving every meal to ensure proper temperatures. Norwood Commercial Appliances came out on 10/05/2023 and plate warmer plug was adjusted and warmer was working and was able to diagnose the problem with fan. Norwood Commercial Appliances was scheduled to return to the	11/3/23

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was able to eat the top portion of the asparagus stalks but that was it.

1b. Resident #8 was admitted to the facility on 07/28/23 with diagnoses that included chronic respiratory failure.

A review of the most recent admission Minimum Data Set (MDS) dated 08/04/23 revealed that Resident #8 was cognitively intact and required supervision with eating.

An observation and interview were conducted with Resident #8 on 10/04/23 at 12:17 PM. Resident #8 was sitting up in bed with her lunch tray sitting on the over bed table with the lid covering the plate of food. Resident #8 stated that she could not eat the lunch meal because the food was cold, and the asparagus were long, cold, and overcooked and "I could not chew them." Resident #8 added, "thank goodness for my friends who brought me something to eat, or I would starve to death."

1c. Resident #18 was admitted to the facility on 12/30/21 with diagnoses that included hemiparesis following a stroke.

Review of the most recent annual Minimum Data Set (MDS) dated 07/04/23 revealed that Resident #18 was cognitively intact and was independent with eating.

An observation and interview were conducted with Resident #18 on 10/04/23 at 12:24 PM. Resident #18 was sitting up in her wheelchair at bedside with her lunch tray in front of her with less than 25% of the lunch meal gone. Resident #18 stated the asparagus was overcooked and

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facility 11/03/2023 to do necessary repairs for proper use and function.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Facility conducted in-service with 100% of all cooks on proper food temperatures and the new process for documenting temperatures prior to serving each meal. Facility contacted company to come to facility to assess the non-working plate warmer and make necessary repairs to ensure that food will retain proper temperature until it reaches the Resident. Facility initiated a new process on checking and documenting food temperatures on serving line prior to serving every meal to ensure proper temperatures.

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

In-service was completed with all Dietary Staff that are cooks regarding proper food temperatures and new process of documenting temperatures prior to serving every meal. Food temperature logs will be audited by Dietary Manager or designee weekly x 4 weeks and monthly x 3 months.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
Monthly Dietary Manager will send a test tray to a random hall in the facility to

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they did not take the ends of them, and the pasta was tough and "was not hot at all" maybe room temperature at best. Resident #18 stated she did enjoy the mandarin oranges that were served for dessert.

1d. Resident #76 was admitted to the facility on 06/19/23 with diagnoses that include moderate protein calorie malnutrition.

Review of the most recent quarterly Minimum Data Set (MDS) dated 08/30/23 revealed that Resident #76 was cognitively intact and was independent with eating.

An observation and interview were conducted with Resident #76 on 10/04/23 at 12:20 PM. Resident #76 was sitting up in bed with her lunch tray in front of her, picking at the food on the plate. She stated, "it's too much garlic, garlic pasta, garlic bread." Resident #76 stated that the pasta was cold, and the asparagus were stringy and overcooked. She added that she like the mandarin oranges that were served for dessert.

An interview was conducted with the Dietary Manager on 10/04/23 at 12:50 PM. The Dietary Manager stated that the dietary department was very short staffed, and he worked a lot of shifts cooking and working the tray line to ensure the residents received their meals. He stated that he had two other cooks that helped fill in on the schedule. The Dietary Manager stated that he had worked at the facility since the end of August 2023. He stated that he did receive resident complaints about cold food, and they had worked hard to address the issues. He stated that he had not had time to attend a resident council meeting since he began working at the facility. The Dietary

F 804

ensure that food is staying at the proper temperature as it reaches the Residents. The Dietary Manager or designee will present to QI committee the results of Audit Tools referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at quarterly QA meeting.

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Manager stated that he ensured the food was hot when it left the kitchen but then it was sitting in the hallway waiting to be passed for a period of time and the food was losing heat during that waiting period. He further explained that the facility had a plate warmer, but it did not work and had not worked since he began working at the facility. He explained that they used a plastic plate bottom with dome lid over the plate and then placed the tray on the closed cart to be delivered to the unit and passed to the resident. The Dietary Manager stated that they did their part to ensure hot food, but the nursing staff had to do their part and pass the trays more quickly.

2. An observation of the lunch tray line was conducted on 10/04/23 at 11:06 AM. A test tray was requested. The menu consisted of chicken alfredo, asparagus, garlic bread, and mandarin oranges. Temperature monitoring was conducted with Cook #1 and revealed the following:

-chicken alfredo-165-degree Fahrenheit
-Asparagus- 168-degree Fahrenheit
-Garlic bread- 189-degree Fahrenheit

The test tray was plated on 10/04/23 at 11:35 AM and sampled at 12:04 PM with the Dietary Manager.

When the lid was removed from the lunch tray there was no visible steam coming from the food. The Dietary Manager agreed that the chicken alfredo had good garlic flavor but was not hot and had already begun to cool and the sauce was hardening and room temperature at best. The asparagus was cold, and the stalk was hard to chew. The garlic bread was hard to chew.

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F 804	Continued From page 19 An interview was conducted with the Dietary Manager on 10/04/23 at 12:50 PM. The Dietary Manager stated that the dietary department was very short staffed, and he worked a lot of shifts cooking and working the tray line to ensure the residents received their meals. He stated that he had two other cooks that helped fill in on the schedule. He stated that he did receive resident complaints about cold food, and they had worked hard to address the issues. He stated that he had not had time to attend a resident council meeting since he began working at the facility. The Dietary Manager stated that he ensured the food was hot when it left the kitchen but then it was sitting in the hallway waiting to be passed for a period of time and the food was losing heat during that waiting period. He further explained that the facility had a plate warmer, but it did not work and had not worked since he began at the facility. He explained that they used a plastic plate bottom with dome lid over the plate and then placed the tray on the closed cart to be delivered to the unit and passed to the resident. The Dietary Manager stated that they did their part to ensure hot food, but the nursing staff had to do their part and pass the trays more quickly to ensure the residents received hot food.	F 804		
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	F 812		11/3/23

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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 staff interviews the facility failed to maintain the final rinse cycle of the high temperature dish machine according to manufacturer's recommendations, failed to remove expired food items from the dry goods storage area, failed to maintain a clean floor free from grease build-up and clean vent on the reach-in cooler and failed to keep the food preparation area free of chemicals and personal drinks. In addition, the facility failed to maintain the walk-in freezer free of ice build-up and failed to discard frozen food with signs of freezer burn. The facility also failed to ensure dietary staff wore hair coverings in the food preparation area. This deficient practice had the potential to affect the food served to residents. The facility census was 88 residents.

The findings included:

1. The manufacturer recommendations for the high temperature dish machine read in part, operating temperature for high temperature sanitizing rinse cycle was 180 degrees Fahrenheit (F).

F 812

Address how corrective action will be accomplished for those residents found to have been affected:
All 88 Residents were identified as being affected for all findings.
For Findings:
1. Facility immediately implemented a temperature log to record the dish machine temperatures when dish machine is used by staff to ensure the correct operating temperature. This log will be audited by the Dietary Manager daily x 3 weeks, weekly x 3 weeks and monthly x 3 months. Any fluctuation in temperature will immediately be reported to Dietary Manager or designee and then reported to maintenance to fix the issue. Inservice of 100% dietary staff was initiated on 10/09/2023 with completion on 10/13/2023 instructing staff to record temperature of dish machine on log each time dish machine with date and time, what the correct operating temperature for high temperature sanitizing rinse cycle, and if any fluctuations in temperature occur or it drops below correct operating

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An observation of the high-temperature dish machine was made on 10/05/23 at 12:29 PM along with the Dietary Aide. The Dietary Aide was observed putting trays of dirty dishes into the dish machine and when they were done pulling the trays out of the other side. The final rinse temperature gauge read 140 degrees F for three back-to-back cycles.

An interview was conducted with the Dietary Aide on 10/05/23 at 12:35 PM. When the Dietary Aide was asked about the final rinse temperature gauge he replied, "I am new and have not been trained on any of the temperatures or how to check them."

The Dietary Manager was interviewed on 10/05/23 at 1:05 PM who confirmed that he had been the Dietary Manager since the end of August 2023. He further stated that he had only had three days of training at another facility. The Dietary Manager stated all the dietary staff including the Dietary Aide were new and had not been trained on the dish machine or how to monitor temperatures. He stated that there were no temperature logs that he could find for this year, he stated he could only find the logs from 2021. The Dietary Manager stated that if the dish machine was not working properly, they would have to switch to the three compartment sink and wash dishes by hand or use plastic utensils until the machine could be fixed. After looking at the dish machine the Dietary Manager stated that he thought maybe the water heater booster was not working because the light on the front of it that would indicate it was on was not coming on. He added that he was certain the light was on yesterday, but he did not check the temperature of the dish machine yesterday to verify that. The

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temperature they are to stop using the dish machine switch to three compartment sink and immediately report the temperature fluctuation to the Dietary Manager or designee. When issue is reported to Dietary Manager or designee it will be reported to Maintenance Director who will assess and coordinate repair if needed.

2. Facility conducted an in-service with 100% of dietary staff was initiated on 10/09/2023 with completion on 10/13/2023 regarding new Weekly Cleaning Schedule which includes checking for expired products three times a week on Monday, Wednesday, and Friday. Dietary staff were in-service that tasks assigned to them on a weekly basis would be posted in the kitchen and would be required to be completed and initialed that they were completed. The Weekly Cleaning Schedule will then be checked by Dietary Manager or designee to ensure that all tasks are completed on a weekly basis. Administrator or designee with audit that all tasks on the Weekly Cleaning Schedule are initialed and the Dietary Manager or designee has initialed that each task was completed weekly x 4 weeks then monthly x 3 months.

3. Facility conducted an in-service with 100% of dietary staff was initiated on 10/09/2023 with completion on 10/13/2023 which included Weekly Cleaning Schedule, not to place personal items in food preparation areas, and correct location for cleaning products to be stored. Weekly Cleaning Schedule will be checked by Dietary Manager or

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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

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Dietary Manager stated he would notify the Maintenance Director and see if he could get the water heater booster to work.

The Administrator was interviewed on 10/05/23 at 2:00 PM. She stated that the Maintenance Director was working on the dish machine and would hopefully have the water heater booster fixed soon. She stated that they had also called the repair company to come out today and take a look at the machine and water heater booster. The Administrator stated that the Dietary Manager was still new to his role and had not had the opportunity to get all the training he needed, which included key systems in the kitchen and one of those systems was using the dish machine properly and ensuring the proper temperatures were reached during operation and maintaining the appropriate logs of those temperatures.

2. An observation of the dry goods storage area was made on 10/02/23 at 9:50 AM along with Dietary Manager. The observation revealed three packs of hamburger buns that expired on 09/24/23 and 12 loaves of bread that expired on 09/29/23.

The Dietary Manager was interviewed on 10/04/23 at 11:30 AM. The Dietary Manager stated that the bread company had delivered to the facility on 10/02/23 and should have taken the expired items with them. However, the Dietary Manager stated that he should have caught the expired items and thrown them away to ensure that they were not served to the residents.

The Administrator was interviewed on 10/05/23 at 3:59 PM who stated that she expected the dietary staff to be checking the expiration dates on all

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designee to ensure that all tasks are completed on a weekly basis. Administrator or designee with audit that all tasks on the Weekly Cleaning Schedule are initialed and the Dietary Manager or designee has initialed that each task was completed weekly x 4 weeks then monthly x 3 months. Audit will be completed by Dietary Manager to check and ensure that there are no personal items and/or cleaning products in food preparation areas. Audit tool will be completed weekly x 4 weeks then monthly x 3 months.

4. Complete clean out of freezer was completed 10/09/2023 with all food with ice build up discarded and ice build up removed from shelving. Company was contacted to assess freezer and temperature was adjusted which resolved the issue with ice building up on or around food stored. Inservice for 100% of dietary staff was initiated on 10/09/2023 with completion on 10/13/2023 regarding ne Weekly Cleaning Schedule which includes checking product in the freezer and typical cleaning of freezer shelving and floor. Audit will be performed by Dietary Manager to ensure that the freezer remains clean and free of ice build up and that all food stored is free from ice build up weekly x 4 weeks then monthly x 3 months.

5. Sister facility arrived with hairnets within 2 hours of the observation which immediately corrected the deficiency. The facility Dietary Manager now checks the quantity of hair nets prior to every order and ensures that the papers inside of the

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	345163	A. BUILDING ______ B. WING ______	C 10/05/2023

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food items and discarding any food item that was expired or nearing its expiration date. The food item should not be on the shelf and available for use past its expiration date.

3. An observation of the kitchen and food preparation area was made on 10/04/23 at 11:00 AM along with the Dietary Manager. The observation revealed: a bottle of cleaning solution sitting on the food preparation table, two personal drinks that belonged to the dietary staff were also sitting on the food preparation table along with food items that were being used to prepare the upcoming lunch and dinner meal. The observation also revealed that the floor area under the deep fryer was coated with a dark, thick, slippery substance with approximately a quarter inch of built up of the dark, think slippery substance. The top of the reach in cooler contained a black slimy substance covering the vent.

The Dietary Manager was interviewed on 10/05/23 at 1:05 PM who stated that he had been the manager since the end of August 2023. He added that shortly after he became the manager the dietary department experienced a lot of turn over and they have been very short staffed. He stated that most days he worked a double shift to ensure the residents got their meals. He stated that a lot of the other duties in the kitchen like the routine cleaning schedule had just been pushed to the back burner until they could get enough staff to resume the schedule. The Dietary Manager stated that the cleaning solution and personal drinks should not have been on the food preparation tables and the equipment in the kitchen should have been cleaned according to the routine schedule but had not been due to the

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box in fact have hairnets in them and are not empty. Dietary Manager is to ensure that all employees in the kitchen are wearing hair nets at all times.
Administrator will do walk through audits at random times on both shifts daily for two weeks then weekly x 3 weeks then monthly x 3 months.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
Facility has identified all Residents admitted to the facility as having the potential to be affected by the same deficient practice.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
1. Temperature log will be audited by the Dietary Manager daily x 3 weeks, weekly x 3 weeks and monthly x 3 months. Any fluctuation in temperature will immediately be reported to Dietary Manager or designee and then reported to maintenance to fix the issue. Inservice of 100% dietary staff was initiated on 10/09/2023 with completion on 10/13/2023 instructing staff to record temperature of dish machine on log each time dish machine with date and time, what the correct operating temperature for high temperature sanitizing rinse cycle, and if any fluctuations in temperature occur or it drops below correct operating temperature they are to stop using the dish machine switch to three compartment sink and immediately report the temperature fluctuation to the Dietary

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F 812	Continued From page 24 staffing shortages. The Administrator was interviewed on 10/05/23 at 3:59 PM. The Administrator explained that for the last couple of months the dietary department had been very short staffed and the Dietary Manager and herself have been working numerous shifts at a time to ensure the residents got their meals. She stated that she had developed a cleaning schedule that was to be done weekly by the dietary staff. The Dietary Manager should be checking behind them to ensure the items were cleaned but the dietary department had not had the staff to do that. The Administrator stated that they have recently hired 4 or 5 additional dietary personnel and she hoped that would allow them to get back on track. 4. An observation of the freezer was made on 10/04/23 at 11:04 AM along with the Dietary Manager. The observation revealed that a thin layer of ice was noted across the right-side floor of the freezer. The shelf unit that sat directly inside the freezer on the right side was noted to have approximately 2 inches of ice buildup. There was a box of unidentifiable food item on that shelf that was covered in approximately 1 inch layer of ice. The Dietary Manager stated that the food item was liquid eggs. The Dietary Manager was interviewed on 10/04/23 at 11:18 AM and stated that he had noticed the ice build up in the freezer and had the repair company come out and they replaced the seals on the freezer door, but it was still getting moisture build up and he was not sure where it was coming from. He added that he had the repair company come back out and they were going to replace the hinges on the freezer and	F 812	Manager or designee. 2. Dietary Manager or designee to ensure that all tasks are completed on a weekly basis. Administrator or designee with audit that all tasks on the Weekly Cleaning Schedule are initialed and the Dietary Manager or designee has initialed that each task was completed weekly x 4 weeks then monthly x 3 months. 3. Administrator or designee with audit that all tasks on the Weekly Cleaning Schedule are initialed and the Dietary Manager or designee has initialed that each task was completed weekly x 4 weeks then monthly x 3 months. Audit will be completed by Dietary Manager to check and ensure that there are no personal items and/or cleaning products in food preparation areas. Audit tool will be completed weekly x 4 weeks then monthly x 3 months. 4. Audit will be performed by Dietary Manager to ensure that the freezer remains clean and free of ice build up and that all food stored is free from ice build up weekly x 4 weeks then monthly x 3 months. 5. Administrator will do walk through audits at random times on both shifts daily for two weeks then weekly x 3 weeks then monthly x 3 months. 6. Education will be continued during orientation for all new staff or agency staff. Then yearly education on Food Storage/Prepare/Serve standard and the sanitary standard of the kitchen. Indicate how the facility plans to monitor its performance to make sure that	

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F 812	Continued From page 25 see if that fixed the problem. He added that he should have discarded the liquid egg as the ice that had built up on it indicated that it may have been freezer burnt. The Administrator was interviewed on 10/05/23 at 3:59 PM and confirmed that the repair company had been to the facility attempting to fix the freezer by replacing the seals on the door. When that did not fix the problem, they were going to come back and replace the hinges and see if that would help. The Administrator stated she was unsure if the ice build up was new since the replacement of the seals or if was there prior to. 5. An observation of the kitchen was made on 10/02/23 at 10:49 AM and revealed 3 staff members (Dietary Manager, Cook, and Dietary Aide) working cleaning up from breakfast and beginning to prepare the food that would be served at lunch. Additional observation at that time revealed none of the kitchen staff wore a hairnet or covering. An interview with the Dietary Manager was conducted on 10/02/23 at 10:51 AM revealed he was not aware until he had come in the facility that morning that they were out of hairnets. He reported none of the staff in the kitchen had anything to put on their heads to prevent hair from contaminating resident food that was prepared and served. The Dietary Manager reported he had requested the facility order more but did not know when the hair nets would arrive. An interview with the Administrator was conducted on 10/02/23 at 11:02 AM revealed she was made aware that the kitchen did not have any hairnets or coverings available for the dietary	F 812	solutions are sustained: The Administrator or designee will present to QI committee will review the results of Audit Tools referenced during monthly QA Meeting for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring for continued compliance for 3 months. Findings will be discussed at quarterly QA meeting.	

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staff to wear. She reported she had placed an order that morning but stated the order would not arrive until the following day. She reported she would try to locate something for the dietary staff to wear in the meantime.

Observations made on 10/02/23 at 3:37 PM revealed all dietary staff wearing hairnets.

A follow-up interview with the Dietary Manager was conducted on 10/05/23 at 1:05 PM revealed a sister facility had delivered hairnets on 10/02/23 for them to use until their order arrived. He verified they had received their new order and that the lack of hairnets being available to his staff was ultimately his responsibility. He reported he did not know how low in stock they were getting because some of his staff would pull the hairnet from the paper wrapper, leaving the wrapper in the box and when he would glance at the box that held the hairnets, it looked as though there were more available than there actually was and he did not realize there were no more until he came in on 10/02/23. He reported he would ensure his staff removed the paper packaging from the box when they got a new hairnet moving forward to ensure the facility did not run out of hairnets again.