| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 10/09/23 through 10/13/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #94BR11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 10/09/23 through 10/13/23. Event ID# 94BR11. The following intakes were investigated NC00194622, NC00196884, NC00197745, NC00202615, NC00204609, NC00205069, NC00206633, NC00207269, and NC00208141. Two (2) of the 20 complaint allegations resulted in deficiency. | F 000 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>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.<br><br>§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.<br><br>§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.<br><br>§483.10(f)(3) The resident has a right to interact | F 561 | | 11/9/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 11/03/2023

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<br>with members of the community and participate in community activities both inside and outside the facility.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident interviews, and staff interviews the facility failed to honor a resident's bathing preference of showers for 1 of 2 residents (Resident #96) reviewed for choices.<br><br>The findings included:<br><br>Resident #96 was readmitted to the facility on 7/6/23 with diagnoses inclusive of anxiety, major depressive disorder, sleep apnea, acid reflux, hyperlipidemia, insomnia, and constipation.<br><br>A uarterly Minimum Data Set assessment dated 7/12/23 indicated Resident #96 was cognitively intact and required extensive assistance with activities of daily living (ADL) and total dependence with bathing.<br><br>A review of the medical record did not indicate Resident #96 refused showers.<br><br>A review of the ADL record for September 2023-October 12, 2023 documented Resident #96 received bed baths only, declined a bed bath once and received no showers.<br><br>During an interview on 10/10/23 at 1:03 PM | F 561 | ACKNOWLEDGEMENT DISCLAIMER:<br>Matthews Health and rehab acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The Plan of Correction is submitted as a written allegation of compliance. Matthews Health and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.<br><br>Tag 0561 - 483.10(f)(1)-(3)(8)<br>Self-Determination (LONG TERM CARE FACILITIES)<br><br>F 561 Self-determination<br>1. On 10/13/23 resident #96 was interviewed immediately to confirm personal preferences and appropriate shower schedules were put into place. | |

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Continued From page 2

Resident #96 indicated his shower days were 3 times per week and that staff stated they were busy since his admission to the facility. He further indicated he may or may not get a shower but once weekly and has never received a shower 3 times per week as scheduled. He stated he did not recall ever refusing a shower because he was usually given a bed bath without discussion about a shower.

During an interview on 10/12/23 at 3:07 PM Nurse #4 revealed Resident #96 was scheduled for showers 3 times per week (Tu, Thurs, Sat) on 2nd shift (3pm-11pm). She further revealed he complained to her at the end of September about not getting showers and she reported it to Nurse #3, his assigned 2nd shift hall nurse. She could not recall him ever refusing care.

During a follow-up interview and observation on 10/13/23 at 10:30 AM, Resident #96 indicated he did not receive a shower on 10/10/23 (Tuesday) or 10/12/23 (Thursday) and that he wanted his showers as scheduled. He further indicated he was told it was too much work to give him a shower since he needed 2 people and the lift to assist. He presented in bed and dressed in a hospital gown with no apparent odors.

During an interview on 10/13/23 at 11:50 AM, Nurse Aide #4 revealed Resident #96 was on her permanent day assignment and his showers were scheduled for 2nd shift. She further revealed he had complained about receiving bed baths instead of the scheduled showers 3 times that he wanted. She stated that she notified the Assistant Director of Nursing (ADON).

During an interview on 10/13/23 at 4:51 PM

F 561

2. All current residents were interviewed to confirm resident□s preference regarding bathing. The medical record task list was updated for any issues identified to accurately reflect resident preference.

3. To prevent this from reoccurring, the director of nursing/designee provided education to all nursing staff regarding resident□s right to self-determination and use of the resident□s Kardex for bathing preference. Completed by 11/9/2023.

4. To validate compliance with resident□s bathing preferences and schedules. Director of nursing or designee will audit 5 bath/shower schedules per week for 12 weeks. The administrator or designee will audit all new admissions weekly for 12 weeks to assure personal preferences related to bathing are noted on the resident□s Kardex.

Results of audits will be brought to Quality Assurance Performance Improvement Meeting by the Administrator for review monthly for a minimum of three months or until compliance is substantiated. Further actions will be determine by the QAPI team.

The Administrator is responsible for implementation of the acceptable plan of correction.

AOC: 11/09/2023

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| F 561 | Continued From page 3<br>Nurse #3 indicated Resident #96 mentioned he wanted a shower on 10/12/23 but did not receive one. She further indicated he had been receiving bed baths instead of showers 3 times per week and provided no reason why nurse aides were not providing him with showers.<br><br>During an interview on 10/13/23 at 5:08 PM Nurse Aide #5 revealed she was permanently assigned to Resident #96 and that he was supposed to have showers 3 times weekly (Tu, Thurs, Sat) although she gave him bed baths instead. She further stated she was unaware he wanted showers instead of bed baths and would verbally offer showers in the future.<br><br>During an interview on 10/13/23 at 4:58 PM the Director of Nursing revealed she reviewed the medical record shower sheets that revealed Resident #96 had received all bed baths instead of showers for the past 30 days (Sept2023- Oct 12,2023). She expected Resident #96 and all residents to receive showers as scheduled. | F 561 | | |
| F 656 SS=B | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain | F 656 | | 11/9/23 |

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| F 656 | Continued From page 4<br>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interviews and record review, the facility failed to develop a care plan that addressed discharge goals and plans for 5 of 9 residents (Residents #94, #89, # 332, #60, and #27) reviewed for comprehensive care | F 656 | Tag 0656 - 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan (LONG TERM CARE FACILITIES)<br>F 656 Develop/Implement Comprehensive Care Plan | |

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| F 656 | Continued From page 5<br>plans.<br><br>Findings included:<br><br>1. Resident #94 was admitted to the facility on 9/5/23.<br><br>The admission Minimum Data Set (MDS) assessment dated 9/27/23 did not indicate whether an active discharge plan was in place for the resident to return to the community. The MDS indicated Resident #94 was not cognitively intact.<br><br>The comprehensive care plan, dated 9/6/23, did not include information that addressed discharge plans or goals.<br><br>On 9/12/23 at 1:57 PM an interview was completed with the Social Worker (SW). She typically wrote the care plan that addressed discharge plans and goals for all the residents. The SW acknowledged there was not a discharge care plan included in Resident #94's comprehensive care plan and said she thought she hadn't completed one since the resident's discharge plans were uncertain when her care plan was developed by the interdisciplinary team.<br><br>During an interview with the Administrator on 9/12/23 at 3:05 PM he stated he was aware that a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. He added he was unsure as to why there were so many residents that had care plans with no discharge goals added. He stated they will begin making sure that every resident has that addressed. | F 656 | 1. Discharge plans for residents #94, #89, #332, #6, #27 were immediately corrected.<br><br>2. To identify other residents that have the potential to be affected by the same deficient practice, the MDS coordinator audited all current resident care plans to ensure Discharge Plans are documented in the resident care plan. Any issues identified were corrected.<br><br>3. To prevent reoccurrence on 11/2/23 the regional director of clinical services provided education to the minimum data set coordinator and facility social worker on resident discharge plan coding requirements, and that every residents care plan reflects the resident’s discharge plan.<br><br>4. To ensure ongoing compliance, the minimum data set coordinator or designee will audit all new admissions weekly for 12 weeks.<br>The results of all audits will be submitted to the Administrator and reviewed during monthly QAPI meetings for a minimum of three months. Further actions will be determined by the QAPI team.<br><br>AOC 11/9/23 | |

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| F 656 | Continued From page 6 | F 656 | | |

2. Resident #89 was admitted to the facility on 1/15/21.

The quarterly MDS assessment dated 7/15/23 revealed Resident #89 was not cognitively intact and there was not an active discharge plan was in place for the resident to return to the community.

The comprehensive care plan, updated 7/12/23, did not include information that addressed discharge plans or goals.

On 9/12/23 at 1:57 PM an interview was completed with the Social Worker (SW). She typically wrote the care plan that addressed discharge plans and goals for all the residents. The SW acknowledged there was not a discharge care plan included in Resident #89's comprehensive care plan and said she thought she hadn't completed one since the resident was planning on staying at the facility indefinitely.

During an interview with the Administrator on 9/12/23 at 3:05 PM he stated he was aware that a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. He added he was unsure as to why there were so many residents that had care plans with no discharge goals added. He stated they will begin making sure that every resident has that addressed.

3. Resident #332 was admitted to the facility on 6/23/23.

The admission MDS assessment dated 6/29/23 revealed Resident #332 had moderate cognitive

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| F 656 | Continued From page 7<br>decline and there was an active discharge plan was in place for the resident to return to the community.<br><br>The comprehensive care plan, updated 6/29/23, did not include information that addressed discharge plans or goals.<br><br>On 9/12/23 at 1:57 PM an interview was completed with the Social Worker (SW). She typically wrote the care plan that addressed discharge plans and goals for all the residents. She stated that one had been done but was unsure why it never made it to the care plan.<br><br>During an interview with the Administrator on 9/12/23 at 3:05 PM he stated he was aware that a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. He added he was unsure as to why there were so many residents that had care plans with no discharge goals added. He stated they will begin making sure that every resident has that addressed.<br><br>4. Resident #60 was admitted to the facility on 10/03/17.<br><br>The quarterly MDS assessment dated 7/29/23 revealed Resident #60 was not cognitively intact and there was not an active discharge plan in place for the resident to return to the community.<br><br>The comprehensive care plan did not include information that addressed discharge plans or goals.<br>On 9/12/23 at 1:57 PM an interview was completed with the Social Worker (SW). She | F 656 | | |

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| F 656 | Continued From page 8 | F 656 | | |

typically wrote the care plan that addressed discharge plans and goals for all the residents. She stated that one had been done but was unsure why it never made it to the care plan.

During an interview with the Administrator on 9/12/23 at 3:05 PM he stated he was aware that a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. He added he was unsure as to why there were so many residents that had care plans with no discharge goals added. He stated they will begin making sure that every resident has that addressed.

5. Resident #27 was admitted to the facility on 4/25/23.

The quarterly MDS assessment dated 5/1/23 revealed Resident #27 was cognitively intact and there was an active discharge plan was in place for the resident to return to the community.

The comprehensive care plan, updated 7/13/23, did not include information that addressed discharge plans or goals.

In an interview with Resident #27 on 9/11/23 at 2:36 PM, she shared her discharge plan was to remain in the facility for long term care.

On 9/12/23 at 1:57 PM an interview was completed with the Social Worker (SW). She typically wrote the care plan that addressed discharge plans and goals for all the residents. She stated that one had been done but was unsure why it never made it to the care plan.

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| F 656 | Continued From page 9<br>During an interview with the Administrator on 9/12/23 at 3:05 PM he stated he was aware that a discharge care plan needed to be developed whether a resident was short term rehabilitation, long term care, or if the discharge plan was unknown. He added he was unsure as to why there were so many residents that had care plans with no discharge goals added. He stated they will begin making sure that every resident has that addressed. | F 656 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the | F 657 | | 11/9/23 |

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comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to revise care plans to reflect behaviors for 1 of 11 residents whose care plans were reviewed (Resident #32).

The findings included:

1.Resident #32 was admitted to the facility on 8/25/22 with diagnoses that included anxiety, depression, and dementia.
A review of nursing progress notes dated 4/10/23, 6/21/23, 9/6/23, 9/12/23, 9/14/23, 10/4/23, and 10/10/23, indicated Resident #32 had incidents of yelling "help, help" and/or was medicated due to yelling behaviors.

A quarterly Minimum Data Set (MDS) assessment dated 9/12/23 indicated Resident # 32 had moderate cognitive impairment. No behaviors were noted.

A Care Plan which was noted as revised on 6/15/23 and 9/20/23 did not indicate Resident # 32 was care planned for behaviors (yelling). It identified the use of psychotropic medications related to anxiety and depression with the goal of remaining free of drug related complications. Interventions included: administer medications as ordered and monitor for side effects and effectiveness, report side effects and adverse reactions of psychotropic medications to the physician.

During an interview on 10/13/23 at 12:03 PM Nurse #2 indicated Resident #32 had yelling

F 657

Tag 0657 - 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision (LONG TERM CARE FACILITIES)

F657- Care Plan timing and Revision:
1. Resident #32's identified behavior was immediately added to their care plan on 10/13/23

2. The Administrator or minimum data set coordinator conducted an audit of all residents identified with behaviors to ensure correct behaviors were care planned. Negative findings were corrected immediately.

3. Director of nursing or designee completed 100% staff education on 11/3/2023 for notifying a member of the management team of resident behaviors noted. On 11/3/2023 director of nursing educated the social services department on completion of behavioral care plans.

4. The Director of nursing or designee will audit 5 identified behaviors or symptoms of behavior weekly for 12 weeks to ensure behaviors accurately care planned.

Results of all audits will be brought to the Quality Assurance Performance Improvement Meeting by The Administrator for review monthly for a minimum of three months or until

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| F 657 | Continued From page 11<br>behaviors daily and although her medications are continuously being adjusted, her yelling continues.<br><br>During an interview on 10/13/23 at 10:42 AM, the MDS coordinator revealed specific nurse progress notes would have alerted the MDS, therefore causing the Care Plan to be updated by the MDS team. She did not know why this did not occur. She further revealed the MDS team discussed behaviors in clinical meetings daily and Resident #32's behaviors should have been identified and added to the care plan but were not. The MDS coordinator revised Resident #32's care plan during the interview. | F 657 | compliance is substantially sustained.<br><br>AOC 11/09/23 | |
| F 804 SS=E | Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation of a breakfast meal test tray, a resident interview (Resident #67), a Resident Council meeting, and staff interviews, the facility failed to provide residents with foods per their preferences for temperature and taste (Residents #3, #7, #15, #24, #47, #58, #64, #67, and #83). This failure had the potential to affect all residents who received food from the dietary department. | F 804 | Tag 0804 - 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp (LONG TERM CARE FACILITIES)<br>¿483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>¿483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and | 11/9/23 |

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| F 804 | Continued From page 12 | F 804 | | |

The findings included:

1a. Resident #67 was admitted to the facility on 3/19/18. A quarterly Minimum Data Set assessment dated 8/14/23 assessed Resident #67 with moderately impaired cognition. Resident #67 was observed in his room on 10/09/23 at 2:10 PM, with a visitor. Resident #67 stated that he received a sloppy joe and French fries, for lunch (10/9/23). He stated that the French fries were delivered cold, and were not good reheated in microwave, so he declined to have his lunch meal reheated. The visitor stated that Resident #67 voiced that his food was often delivered cold, staff offered to reheat it, but sometimes he refused and stated that some foods were not good reheated in the microwave.

1b. During a Resident Council Meeting on 10/10/23 at 10:46 AM, 8 of 8 Residents in attendance (Residents #3, #7, #15, #24, #47, #58, #64, and #83) were identified by the activity director (AD) with intact cognition as evidenced by a Brief Interview for Mental Status score of 13 or higher. All residents resided on either the 100, 200 or 400 halls and 6 of the 8 Residents resided on the 100-hall. During the meeting, Residents expressed that their meals were delivered too late which made them cold, the food was not good when it was delivered cold, especially the breakfast meal, which was often delivered "ice cold," because the meal delivery schedule was "not up to par." They said they could not get a good meal and that they did not like the food. They described the meats as tough, the food needed better seasoning, and stated that the food was "pretty much terrible."

appearance;

¿483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.

F804- Palatable/Temperature
1. Residents #3, #7, #15, #24, #47,#58, #64, #67 and #83 were immediately provided with hot meals.

2. To identify others with the potential to be effected, the dietary manager or designee interviewed all interview able residents to determine if their food temperature was a palatable temperature. Any concerns were immediately addressed.

3. 100% of dietary staff in-serviced on 11/2/2023 by administrator for correct hot and cold holding temperatures. 100% Nursing Staff was educated on by director of nursing or designee for timely/appropriate passing of meals trays. Completed 11/09/23. New hires will be educated during on-boarding and orientation.

4. To monitor and maintain compliance the administrator or designee will audit hot food temperatures on 10 random test trays weekly for 4 weeks and then 5 random test trays weekly for 8 weeks. The administrator or designee will randomly audit meal delivery times 5 times per week for 12 weeks. The administrator or designee will randomly audit hot and cold food temperatures on

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During a follow up interview, after the Resident Council meeting, Resident #3 stated on 10/10/23 at 12:24 and on 10/13/23 at 11:59 AM, that her family brought her food because the food was getting worse, she got the same food all the time and it was always cold.

Resident #58 stated on 10/13/23 at 11:37 AM during a follow up interview after the Resident Council meeting that the food was always cold, especially the eggs, which she expressed was because the meal cart was delivered to the 100-hall and sat on the unit for a while before the trays were served.

The activity director (AD) was interviewed on 10/13/23 at 2:00 PM. The AD stated that she had been the AD for the past 4 months, it was her responsibility to record the minutes during Resident Council meetings. The AD stated dietary concerns regarding food palatability was a repeated topic of discussion. The AD stated that residents expressed repeated concerns that the food was cold and that they did not like the food. The AD stated that she discussed all resident concerns from these meetings during the daily morning management meetings so that all department managers were aware of any resident concerns.

1c. An observation on 10/11/23 at 8:30 AM of a breakfast meal test tray was conducted with the dietary manager (DM). A test tray was requested for delivery to the 100-hall. The meal included grits, scrambled eggs, biscuit, pureed grits, pureed eggs, pureed sausage, and milk. The test tray left the kitchen on an open cart at 8:43 AM, arrived to the 100-hall at 8:45 AM and staff started meal delivery at 8:50 AM. All trays were

the kitchen service line 5 times per week for 12 weeks.

All audits will be reported to the QAA Committee for three months or until such time consistent substantial compliance has been achieved as determined by the committee.

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delivered to residents by 9:05 AM. The test tray was observed at 9:05 AM without visible steam coming from the food, the food was slightly warm, but not hot and the pureed eggs were bland and lacked seasoning. The DM agreed that the food was not hot.

During an interview on 10/11/23 at 10:14 AM with the DM she stated that the dietary department received complaints of cold foods in August 2023 from Resident Council regarding cold food to the 400-hall. The registered dietitian (RD) Consultant conducted a tray delivery audit in August 2023 as a follow up to complaints of cold food and identified that meal trays remained in the dining room for residents who ate meals in their rooms. The DM stated that rather than nursing staff taking the resident their meal, the trays remained in the dining room until all the other trays were passed in the dining room. The DM stated this may have contributed to residents receiving cold food. The DM stated staff were educated to let dietary know trays were on the wrong cart for delivery so that dietary could put the resident's tray on the right cart for faster delivery. The DM also stated that in response to the complaints of cold food, the rotation of tray delivery was changed so that the same hall did not always receive their meals last. The DM stated then residents on the 100 and 200 halls complained of cold foods, so she conducted test trays on those halls. The DM identified that it took approximately 25 minutes to deliver all the trays to residents on those halls. She stated the follow up was to deliver meal trays sooner and pass out trays as soon as the cart was on the halls. She stated previously she had more complaints of cold food from residents on the 400-hall, but now most of the complaints regarding cold food were for

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residents who resided on the 100-hall. The DM stated that she would have to review the meal delivery rotation schedule again to address the current concerns with complaints of cold food. The DM stated that because of the "room temperature" foods identified on the breakfast meal test tray conducted that morning (10/11/23) she spoke with the administrator and recommended plate warmers to assist with serving residents hot food.

Nurse #1 was interviewed on 10/12/23 at 10:23 AM and stated that she was assigned on the 100-hall and worked 7 AM to 3 PM. Nurse #1 stated that residents on the 100-hall often complained about food being cold or over cooked and that the past weekend, residents complained about the way the food tasted.

The RD Consultant stated in an interview on 10/13/23 at 10:38 AM that she was the RD Consultant at the facility since July 2023, she consulted at the facility at least quarterly and that another RD Consultant visited at least monthly in an interim role. The RD Consultant stated that she conducted tray delivery audits quarterly during her visits. The RD Consultant stated the last tray delivery audit she conducted was 8/22/23 because residents complained of cold food. The RD Consultant stated during the tray delivery audit that she conducted on 8/22/23, she observed that meal trays were delivered on an open cart to the main dining room for residents who ate in their rooms. The RD Consultant stated nursing staff were observed to place these meal trays on a separate cart that remained in the dining room until all residents who ate in the dining room were served. The RD Consultant stated this was identified as a contributing factor

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in complaints about cold food. She stated that nursing staff were educated to take the tray to the resident or return it to the dietary department rather than leaving the meal tray on an open cart. The RD Consultant stated she expected the dietary department to work with nursing staff to provide residents with hot foods. The RD Consultant provided documentation of the meal tray delivery audit conducted on 8/22/23 for review.

During an interview with the administrator on 10/13/23 at 12:08 PM, he stated that any new and unresolved resident concerns voiced during Resident Council was discussed during daily morning management meetings. He stated that he reviewed the minutes from the 10/4/23 Resident Council meeting and he was aware of resident complaints of cold food and the tray delivery times. He stated the management team discussed a rotated meal delivery schedule so that no hall was the last one served at every meal and residents who attended Resident Council agreed. He stated that the facility was currently working through the meal delivery changes and that residents felt that cold food was still an issue. The administrator stated that residents were encouraged to come to the dining room for meals because of the operational challenges that occurred when residents chose to eat in their rooms. The Administrator stated that microwaves were available on each unit to reheat food for residents who preferred to eat in their rooms. He stated that he knew that reheated food in the microwave was not the best approach, but it was a way to accommodate residents who wanted to eat meals in their rooms. He stated that the facility received new insulated dome lids for the

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| F 804 | Continued From page 17<br>tray line system, and that a corporate request was submitted for a plate warmer and an enclosed cart, which had not yet been approved. | F 804 | | |
| F 806 SS=D | Resident Allergies, Preferences, Substitutes<br>CFR(s): 483.60(d)(4)(5)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;<br><br>§483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to provide preferences for 1 of 3 sampled residents (#178), reviewed for food preferences.<br><br>The findings included:<br><br>Resident # 178 was admitted to the facility on 6/7/23 and discharged on 7/3/23. Diagnoses included anemia, type 2 diabetes with ketoacidosis, and fibromyalgia.<br><br>An admission Minimum Data Set assessment dated 6/9/23 indicated Resident #178's cognition was intact, and she required limited assistance with transfers, bed mobility, dressing and toileting, while she was independent with eating and personal hygiene.<br><br>A Care Plan dated 6/8/23 revealed Resident #178 | F 806 | Tag 0806 - 483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes (LONG TERM CARE FACILITIES)<br>¿483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>¿483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences;<br><br>¿483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;<br><br>F806- Resident Allergies, Preferences, Substitutes:<br>1. Resident #178 discharged from facility on 07/03/23. | 11/9/23 |

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F 806

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was at risk for unstable blood glucose related to diabetes with the goal to remain free of symptoms and complications related to hyperglycemia. Interventions included: administer insulin as prescribed by the physician, assess blood glucose levels as ordered and as needed.

A Care Plan dated 6/12/23 revealed Resident #178 was at risk for hyperglycemic episodes related to insulin dependent diabetes mellitus with a goal to be free from its symptoms through the next review period. Interventions included: blood sugars and sliding scale insulin medications per orders and as needed; follow facility protocol for hyperglycemic episodes and monitor meal intake.

A review of the medical record indicated the meal preferences form dated 6/8/23 was entered but not completed for Resident #178.

A review of a physician order dated 6/12/23 indicated a low concentrated sweets diet (LCS) with verbal thin consistency was ordered for Resident #178.

A telephone interview on 10/11/23 at 2:45 PM, Resident #178 revealed she had type 2 diabetes and did not receive diabetic friendly meals. She further revealed dietary staff did not ask her about her preferences and she did not receive a visit from the dietician until 8 days after she was admitted to the facility. She stated the elevated blood sugars occurred on most days throughout her stay and she had informed staff about her diet concerns/ food preferences. She also stated she received her prescribed insulin on a sliding scale; however, her meal intake and food preferences were also part of the blood sugar management.

F 806

2. All residents have the potential to be affected by this alleged non-compliance. A diet Audit was completed by the director of nursing or designee on all current residents to identify any specialty diets to ensure accuracy. Any findings were corrected immediately.

3. On 11/3/2023 the dietary manager or designee re-educated the dietary department regarding the importance of serving appropriate food preferences/substitutes. New hires will be educated during on-boarding and orientation. On 11/3/2023 the administrator educated the dietary services manager on obtaining food preferences for new admissions within 48 hours of admission.

4. The administrator or designee will audit all new admissions weekly for 12 weeks to assure food preferences were obtained within 48 hours. The administrator or designee will randomly audit 15 trays per week for 12 weeks to assure food preferences are being followed.

All audits will be reported to the QAA Committee for three months or until such time consistent substantial compliance has been achieved as determined by the committee.

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| F 806 | Continued From page 19<br>During an interview on 10/12/23 at 9:28 AM the Dietary Manager indicated she was responsible for obtaining resident food preferences within 48 hours of their admission and did not recall meeting with Resident #178 to collect her preferences or enter the preferences into the medical record.<br><br>During an interview on 10/13/23 at 10:00 AM, the Corporate Registered Dietician Consultant revealed the facility provided a regular diet that was carbohydrate consistent with unsweetened beverages and ½ portioned desserts as opposed to a diabetic diet. Based on the carbohydrate consistent diet, a Resident can tailor it to their preferences. Her expectation was for Resident #178's food preferences to be obtained, documented, and honored by dietary within 48 hours of admission. | F 806 | | |
| F 809 SS=E | Frequency of Meals/Snacks at Bedtime<br>CFR(s): 483.60(f)(1)-(3)<br><br>§483.60(f) Frequency of Meals<br>§483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.<br><br>§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.<br><br>§483.60(f)(3) Suitable, nourishing alternative | F 809 | | 11/9/23 |

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meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interviews, the facility failed to provide snacks to 7 of 8 residents when requested, (Residents #7, #15, #24, #47, #58, #64 and #83).

The findings included:

1a. The minutes from the 10/4/23 Resident Council meeting documented that residents were advised that snacks were delivered every evening to each hall and available on snack trays to include sandwiches (peanut butter/jelly, egg salad, cheese, and chicken salad).

1b. During a Resident Council Meeting on 10/10/23 at 10:46 AM, Residents in attendance were identified by the Activity Director (AD) with intact cognition as evidenced by a Brief Interview for Mental Status score of 13 or higher. During the meeting, Residents #7, #15, #24, #47, #58, #64 and #83 stated that evening snacks were not provided regularly. Residents stated that "sometimes we get them, but most of the time we don't." Residents stated that they voiced a concern related to not being offered evening snacks regularly at the 10/4/23 Resident Council meeting and that dietary staff told them that snacks were delivered every evening to each hall and available on snack trays for nursing staff to pass out. The Residents stated that they wanted evening snacks and wanted staff to offer them snacks, but that even after expressing a concern at the Resident Council Meeting on 10/4/23, staff

F 809

Tag 0809 - 483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime (LONG TERM CARE FACILITIES)
¿483.60(f) Frequency of Meals
¿483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.

¿483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

¿483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.

F809- HS Snacks
1. Immediately following identification, residents #7, #15, #24, #47, #58, #64, and #83 received HS Snacks as requested.

2. All residents have the potential to be

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still did not offer snacks as requested.

Resident #58 stated on 10/13/23 at 11:37 AM during a follow up interview that until 2 weeks ago there were no snacks available for her to get at bedtime.

1c. An observation with the Dietary Manager (DM) occurred on 10/11/23 from 10:30 AM to 10:46 AM of the nourishment rooms on the 100, 200, 300 and 400 halls. Snacks were observed available in each nourishment room pantry and refrigerator. The DM stated during the observations that dietary staff checked the availability of snacks in each nourishment room daily and replenished the snacks every 3 days or as needed. The DM stated that nursing staff were responsible for passing out snacks to residents at 7:30 pm each night.

An interview on 10/13/23 at 1:20 PM with Nurse Aide (NA) #1 revealed NA #1 worked the 3 PM - 11 PM shift on the 100-hall. NA #1 stated in interview "I don't ask every night if residents want snacks, sometimes I give them, if they're not asleep."

An interview with the Activity Director (AD) occurred on 10/13/23 at 2:00 PM. The AD stated that she had been the AD for the past 4 months and that it was her responsibility to record the minutes during Resident Council meetings. The AD stated that the meetings started with dietary staff in attendance which allowed residents to discuss the meal of the month and any dietary updates. The AD stated that after this discussion, dietary staff left the meeting and residents were offered an opportunity to discuss any department concerns without staff present. The AD stated

F 809

effected. HS snacks were made immediately available for all units and offered to residents as desired.

3. Administrator or designee educated all nursing and dietary staff on offering and providing a bedtime snack. Completed 11/09/23. New hires will receive education upon hire.

4. Administrator or designee will audit 5 times per week for 12 weeks that snacks were made available to all units. Administrator or designee will randomly interview 5 interview-able residents per week to assure HS snacks were offered.

The Administrator will report the results of the audits to the QAPI committee for review and recommendation for a Minimum of three months.

AOC 11/09/23

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| F 809 | Continued From page 22 | F 809 | | |

that dietary concerns regarding food was a repeated topic of discussion. The AD stated she recorded resident concerns that were expressed during the meeting and the written concern was given to each department for follow up as needed. The AD stated that she discussed all resident concerns during the daily morning management meetings that were expressed during Resident Council meetings so that all department managers were aware of any resident concerns.

A follow up interview on 10/13/23 at 2:47 PM with the DM revealed she did not attend the 10/4/23 Resident Council Meeting but sent dietary staff in her place and therefore she was not aware that Residents expressed a concern with receiving evening snacks. She stated she attended daily morning management meetings but did not recall evening snacks being discussed and that she would have to check to see if she had a written concern regarding evening snacks. She stated that dietary staff restocked the snacks in each nourishment room every 3 days and as needed. Nursing staff were responsible for offering snacks to residents.

The Registered Dietitian (RD) Consultant stated in an interview on 10/13/23 at 10:38 AM that she was the RD Consultant at the facility since July 2023, she consulted at the facility at least quarterly and that another RD Consultant visited at least monthly in an interim role. The RD Consultant stated she expected notification by the DM of any dietary concerns, but she was not aware of resident concerns related to evening snacks. The RD Consultant stated residents should be offered and provided snacks between meals as ordered and as requested.

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| F 809 | Continued From page 23<br><br>The Administrator stated in an interview on 10/13/23 at 12:08 PM that any new and unresolved resident concerns voiced during Resident Council was discussed during daily morning management meetings. He stated that he reviewed the minutes from the 10/4/23 Resident Council meeting and that dietary staff stocked the nourishment rooms with snacks that nursing staff were responsible for offering and providing to residents. | F 809 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to discard expired and unlabeled food items stored for use, in 1 of 1 | F 812 | Tag 0812 - 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitar y (LONG TERM CARE FACILITIES) | 11/9/23 |

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| F 812 | Continued From page 24<br>reach-in refrigerator, 1 of 1 walk-in refrigerator, and 2 of 4 nourishment refrigerators (halls 100 & 400). The facility also failed to maintain clean ceiling pipes free from tears and stains for 1 of 1 dry goods storage room used to store food served to residents.<br><br>The findings included:<br><br>During a continuous observation of the kitchen on 10/9/23 at 11:05 AM with the Director of Food Service, the following was revealed:<br>Open container of cottage cheese (16 oz) with best buy date of 10/8/23 in reach-in refrigerator.<br>Open container of mustard (1 gallon) with best by date of 4/27/22 in walk-in refrigerator.<br>Open and unlabeled (no date opened and/no date expired) container of salad dressing (1 gallon) in walk-in refrigerator.<br>Ripped and hanging outer covering insulation of ceiling pipes with black stains in the dry storage room.<br>Dried food debris and dried liquid-stained foam ceiling tiles throughout the kitchen and over the steam table.<br><br>During a continuous observation with the Director of Food Service, of nourishment refrigerators (halls: 100, 200, 300, 400) on 10/11/23 at 10:35 AM- 11:00 AM, the following food items were stored for use without a label and/or date to indicate how long the items were good for:<br><br>Frozen package of strawberries in the nourishment room freezer on hall 100.<br>Frozen package of broccoli in the nourishment room freezer on hall 100 hall.<br>Bag of fast food in the nourishment room refrigerator on hall 100. | F 812 | ¿483.60(i) Food safety requirements.<br>The facility must -<br><br>¿483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>¿483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>F812-Food Procurement, Storage/Prepare/Serve-Sanitary:<br>1. Immediate actions were taken to discard expired/and or unlabeled food items, clean and re-cover ceiling pipes, and replace ceiling tiles.<br><br>2. All residents have the potential to be affected. The administrator immediately performed an audit of refrigerators in the kitchen and nourishment rooms to ensure there were no expired or unlabeled food items. No negative findings.<br><br>3. On 10/16/2023 the Administrator and | |

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| F 812 | Continued From page 25<br>Opened container of coffee creamer in the nourishment room refrigerator on hall 400.<br>Package of cheese and crackers snack in nourishment room refrigerator on hall 400.<br><br>During an interview on 10/9/23 at 11:05 AM the Dietary Director indicated she was not aware the expired items had not been discarded and that all dietary staff were responsible for checking for expired, unlabeled foods or best buy dates. She expected all opened foods to be labeled with date opened and use by date.<br><br>During a follow-up observation (accompanied by the Administrator) and interview on 10/11/23 at 1:45 PM, the Administrator observed the torn/ hanging outer casing of the ceiling pipes and pipes throughout the storage room that were stained with black colored spots. He revealed that he was aware of the damaged outer casing of the pipes that needed repair and planned to schedule a repair order. The Administrator further observed the dried food debris and dried liquid-stained foam ceiling panels throughout the kitchen (over the steam table and food prep area). He further revealed he expected the issues to have been repaired since it was previously identified. | F 812 | Regional Dietician educated Dietary Manager and kitchen staff on policies and procedures for labeling opened food items and discarding expired food items. New hires will be educated upon hire. Dietary manager was educated on 11/3/2023 by administrator on how to identify soiled or unsanitary physical plant issues and appropriately request a maintenance work order. On 11/6/2023 the administrator or designee educated 100% Nursing staff and Housekeeping on storage of food items, labeling of food items, and discarding of unlabeled/expired food items in Nourishment rooms.<br><br>4. The Administrator or designee will audit nourishment room refrigerators 5 times per week for 12 weeks to ensure no unlabeled or out of date food items are stored. The administrator or designee will audit the dietary department 5 times per week for 12 weeks to ensure proper food storage and kitchen sanitation. The administrator or maintenance director will audit ceilings, and pipes in the kitchen 5 times per week for 12 weeks to ensure there are no unsanitary physical plant issues.<br>The Administrator will report the results of the monitoring to the QAPI committee for review and recommendation for a Minimum of three months.<br><br>AOC 11/09/23. | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) | F 867 | | 11/9/23 |

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| F 867 | Continued From page 26<br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. | F 867 | | |

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| F 867 | Continued From page 27<br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. | F 867 | | |

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| F 867 | Continued From page 28<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint | F 867 | Tag 0867 - 483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities (LONG TERM CARE FACILITIES)<br><br>F867: QAPI/QAA Improvement Activities Corrective Action: | |

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F 867

Continued From page 29

investigation survey completed on 06/09/22. This was for one repeat deficiency originally cited in the area of food procurement, store, prepare, serve, sanitary that was subsequently recited on the current recertification and complaint investigation survey of 10/13/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.

The findings included:

This tag is cross referenced to:

F812: Based on observations, record review and staff interviews, the facility failed to discard expired and unlabeled food items stored for use, in 1 of 1 reach-in refrigerator, 1 of 1 walk-in refrigerator, and 2 of 4 nourishment refrigerators (halls 100 & 400). The facility also failed to maintain clean ceiling pipes free from tears and stains for 1 of 1 dry goods storage room used to store food served to residents.

During the recertification and complaint investigation survey of 06/09/22, the facility failed remove excessive ice buildup in the ice cream freezer, clean the hand sink, remove food debris from baking sheets and remove dust from ice machine vents.

The administrator stated in an interview on 10/13/23 at 2:18 PM that the QAA committee met every month with the director of nursing, director of rehab, activity director, social worker, business office manager, pharmacy, the dietary manager, and other department managers as needed. He stated that the agenda included corporate

F 867

1. The Quality Assurance Process was re-evaluated by the Administrator and the DON on 10/16/23 including monitoring for F812. The Administrator and the DON reviewed the Federal Regulation for tags.

2. On 11/03/23- The Administrator and the DON reviewed the QA minutes and QA audits for the past six months to identify any needs for additional monitoring.

3. On 11/03/23- The Administrator and the DON were re-educated by the Regional Vice President of Operations related to requirements of F867.

4. The Administrator/Designee will complete a QPAI Audit Tool Monthly for a minimum of three months to ensure systems and processes continue to be monitored and follow up completed as required.
Results of the audit will be brought to the Quality Assurance Performance Improvement Meeting by The Administrator for review. If any discrepancies are noted, further action will be implemented by the Administrator.

AOC 11/9/23

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| F 867 | Continued From page 30<br>directives and facility specific concerns which included the outcome of previous surveys. The administrator stated that he attributed a repeat deficiency in the dietary department to the broad array of regulatory areas in that department as evidenced by the leak in the dumpster identified in the June 2022 survey and the food storage and sanitation concerns identified in the current survey. He stated that there was a breakdown in the facility's QAA follow-up that addressed the specific issues identified at the last survey but did not branch out to identify other sanitation concerns. The administrator stated that the kitchen sanitation tag included all areas of concern in the dietary department, but the QAA process was geared to focus on the current areas non-compliance and to address specific areas to prevent repeat deficiencies in those specific areas. | F 867 | | |