STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345351	A. BUILDING ______ B. WING ______	C 11/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SALUDA	**501 ESSEOLA CIRCLE SALUDA, NC 28773**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/29/23 through 11/1/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KI9311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/29/23 through 11/1/23. Event ID # KI9311. The following intakes were investigated NC00199275, NC00205940, NC00200016. Ten (10) of 10 complaint allegations did not result in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to assess the ability of a resident to self-administer medications for 1 of 4 sampled residents observed with medications at bedside (Resident #64). Findings included: Resident #64 was admitted to the facility on 05/15/23. His diagnoses included congestive heart failure, diabetes, and left shoulder pain. The quarterly Minimum Data Set (MDS) dated 09/27/23 revealed Resident #64 had intact	F 554	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 11/28/23 a medication self-administration assessment was completed on Resident #64. #64 was interviewed by the Director of Nursing and declined to self-administer their own medications. 2. Address how the facility will identify other residents having the potential to be affected by the deficient practice.	11/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/24/2023

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 554

Continued From page 1

cognition.

Review of the medical record revealed no documentation that Resident #64 was assessed for self-administration of medications.

During an observation and interview on 10/31/23 at 1:05 PM, Resident #64 was sitting up on the side of his bed with the overbed table pulled directly in front of him and placed on top of the overbed table was his lunch tray and a medicine cup containing 2 round white pills. Resident #64 explained earlier that morning he had 3 teeth pulled and the pills in the medicine cup were the Tylenol he requested for pain that Nurse #1 had left for him to take. Resident #64 stated he was capable of taking his medications on his own but the nurse usually stayed in the room with him while he took his medications.

During an interview on 10/31/23 at 1:11 PM, Nurse #1 revealed she usually stayed in the room with Resident #64 as he took his oral medications; however, when she brought Resident #64 his PRN (as needed) Tylenol for pain, she got distracted when staff brought him his lunch tray. Nurse #1 explained she left the medications with Resident #64 and returned to her medication cart to continue with her medication pass. Nurse #1 stated Resident #64 had not been assessed to self-administer medications and she should have remained in the room with Resident #64 while he took his oral medications.

During interviews on 10/31/23 at 2:40 PM and 11/01/23 at 5:45 PM, the Director of Nursing (DON) stated nurses were expected to wait at bedside for the resident to take their oral

F 554

To identify other residents with this same issue, on 11/28/23 the Director of Nursing or designee interviewed all alert and oriented residents if they preferred to self-administer their medications. A self-administration assessment was completed on any resident that elected to self-administer their medication and their care plan was updated. On 11/1/23 the Director of Nursing conducted a room sweep of all resident rooms to ensure there were no other residents with medications at bedside who were not care planned or assessed for self-administration of medications. No other issues were found.

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

To prevent this from recurring, on 11/17/23 the Director of Nursing or designee educated all licensed nurses not to allow residents to self-administer medications unless they have been assessed for self-administration of medications. The Social Worker was educated to include interviewing residents on their desire to self-administer medications on admission and during their quarterly care plans. The Social Worker will notify the Director of Nursing that the resident wishes to self-administer medications. All newly hired licensed nurses, agency licensed nurses and new social workers will receive this same

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F 554	Continued From page 2 medications prior to leaving the room and not leave medications unattended at the resident's bedside. The DON confirmed Resident #64 had not been assessed to self-administer his medications and stated Nurse #1 should have stayed in the room with Resident #64 while he took his oral medications. During an interview on 11/01/23 at 6:16 PM, the Administrator stated nursing staff knew to stay in the room with the resident while they took their oral medications. He further stated nursing staff should never leave medications unattended in the resident's room.	F 554	education prior to working with residents. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained To monitor and maintain ongoing compliance beginning 11/20/23 the Director of Nursing or designee will conduct 2 medication administration audits weekly, 10 resident room sweeps for medication at bedside weekly for preference to self-administer medications for 12 weeks. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. The Administrator is responsible for compliance Date of Completion is 11/29/23	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		11/29/23

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F 565 Continued From page 3
providing assistance and responding to written requests that result from group meetings.
(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.
(A) The facility must be able to demonstrate their response and rationale for such response.
(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident and staff interviews, the facility failed to resolve and communicate the facility's efforts to address repeated dietary and staffing concerns voiced by residents during Resident Council meetings for 7 of 9 months reviewed (February 2023, April 2023, May 2023, June 2023, July 2023, September 2023, and October 2023).

Findings included:

The Resident Council minutes for the period January 2023 through October 2023 were reviewed and revealed the following:
Resident Council minutes dated 02/22/23 noted in part, residents voiced staffing concerns that

F 565

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The issues identified, specifically staffing at night and dietary concerns were addressed by the Administrator on 11/22/23 at the scheduled Resident Council Meeting. Residents were satisfied with the plan on addressing their concerns going forward.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

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F 565	Continued From page 4 third shift agency staff talked loudly in the halls, did not answer call lights, and wore ear buds to talk on their cellphones. In addition, food on the meal trays were served cold and ice cream was not kept cold. Resident Council minutes dated 03/29/23 noted the staffing and dietary concerns voiced during the previous month's meeting were reviewed and reported as resolved. There were no new staffing or dietary concerns noted as voiced during the meeting. Resident Council minutes dated 04/26/23 noted in part, residents voiced dietary concerns related to menu inconsistency and meals being served late. In addition, residents voiced staffing concerns with third shift staff being too loud and Nurse Aides (NAs) taking too long to answer call lights. Resident Council minutes dated 05/31/23 noted in part, the Administrator and Director of Nursing (DON) addressed the previous month's concerns related to staffing and dietary and all were noted as resolved. Under New Business it was noted residents voiced concerns that NAs took too long to provide assistance when requested. Resident Council minutes dated 06/28/23 noted the staffing concerns voiced during the previous month's meeting were reviewed and noted as resolved. Under New Business it was noted residents voiced concerns with NAs talking on their cellphones. Resident Council minutes dated 07/26/23 noted the staffing concerns voiced during the previous month's meeting were reviewed and noted as resolved. Under New Business it was noted residents voiced continued concerns with NAs cellphone use. Resident Council minutes dated 08/30/23 revealed no indication that the concerns voiced	F 565	All residents have the potential to be affected. Administrator will start a sub-committee of resident council to discuss dietary concerns to meet the 1st and 3rd Wednesday of the month prior to resident council, this meeting will be chaired by the Dietary Manager, this was discussed in the 11/22/23 resident council meeting. Administrator and/or designee will report steps taken regarding the staffing issues to resident council on a monthly basis starting with the 11/22/23 Resident Council Meeting. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Administrator will educate department heads regarding policies and procedures related to resident concerns and addressing at Resident Council. Social Worker and Activities Director will review grievances/concerns from previous month's meeting at resident council to ensure grievance/concern has been addressed. Resident Council will invite department heads to attend resident council as needed. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Administrator and/or designee will interview 5 residents per week for 12 weeks beginning 11/24/23 to ensure	

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F 565	Continued From page 5 during the previous month's meeting regarding cellphone use were reviewed, resolved or remained ongoing. There were no new staffing or dietary concerns noted as voiced during the meeting. Resident Council minutes dated 09/27/23 noted in part, there was no old business to review from the previous month's meeting. Under New Business it was noted residents voiced concerns that staff were eating resident snacks from the snack cart and requested dietary use plate warmers on meal trays to keep food warm. Resident Council minutes dated 10/25/23 noted the dietary and staffing concerns voiced from the previous month's meeting were reviewed and noted as resolved. Under new business it was noted residents voiced concerns with being served cold food, cold coffee, and melted ice cream. The facility's grievance logs for the period January 2023 through September 2023 were reviewed. Grievances filed on behalf of the Resident Council related to the concerns voiced during the monthly meetings were all noted as resolved. During an interview on 10/29/23 at 2:05 PM, the Dietary Manager revealed she attended Resident Council Meetings and was aware of the food concerns voiced by residents. The Dietary Manager did not provide any explanation as to what was or had been done to address the food concerns. A Resident Council group interview was conducted on 11/01/23 at 10:01 AM with Resident #14, Resident #16, Resident #19, Resident #33, Resident #47, Resident #65, Resident #74,	F 565	concerns are being addressed timely and sufficiently. Administrator or designee will review resident council minutes for concern/grievances and proper follow-up for 12 weeks beginning with the 11/29/23 Resident Council Meeting. The Administrator will report the results of the monitoring of resident council minutes and resident interviews to the QAPI committee for review and recommendation for a minimum of three months. Completion Date: 11/29/23	

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F 565	Continued From page 6	F 565		

Resident #75, Resident #78 and Resident #80 in attendance. The residents all reported ongoing dietary concerns, specifically with meals being served cold. The residents were in agreement that when meals were served not everyone received a bottom plate warmer just a cover over the plate and the food was usually cold and ice cream melted by the time they were served their meal tray. In addition, residents stated there was inconsistency in what they had ordered for lunch or dinner and what they actually received. The residents also reported ongoing staffing concerns regarding agency staff at night taking too long to answer their call lights and staying on their cellphones. The residents all stated they had voiced these concerns during previous meetings and the usual follow-up they received from staff was "we are working on it." The residents stated while they felt facility staff tried to address the concerns voiced during the Resident Council meetings, they hadn't noticed much improvement and they really didn't receive feedback from administration on the efforts that had been made or attempted to resolve the concerns.

During an interview on 11/01/23 at 3:17 PM, the Social Worker (SW) revealed she attended the Resident Council meetings to transcribe the minutes and any concerns voiced, she documented them on a grievance form and turned them into the appropriate Department Manager to address. The SW confirmed residents did bring up repetitive concerns during the monthly meetings, mainly related to dietary and staffing. She explained typically, the resolution was discussed individually with the person voicing the concern. During the next Resident Council meeting, they reviewed the general concern under old business to see if the

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F 565	Continued From page 7 concern was resolved or remained ongoing but did not have an in-depth group discussion on the attempts being made to address the repeated concerns. During an interview on 11/01/23 at 3:47 PM, the Activity Director revealed while she facilitated the Resident Council meeting, the SW, who also attended, documented the minutes and concerns voiced by the residents. The Activity Director stated for the past year and a half, the residents attending the Resident Council meetings brought up the same concerns month-to-month related to food, dietary and staffing. The Activity Director explained that when concerns were voiced during the meeting, they were addressed and usually discussed with the individual who voiced the concern. She stated during the next Resident Council meeting, they reviewed the general concern under old business to see if it was resolved or remained ongoing but didn't necessarily discuss in detail the efforts being made to address the repeated concerns. During an interview on 11/01/23 at 6:16 PM, the Administrator stated he was aware there had been repeated dietary and staffing concerns voiced during Resident Council meetings. The Administrator explained he did try to discuss resolution efforts with the Resident Council group regarding the concerns they voiced but realized he could definitely improve on his communication to them so they felt more part of the solution and better informed.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		11/29/23

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F 641	Continued From page 8 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASRR) and wandering behavior for 3 of 22 sampled residents reviewed (Residents #10, #26 and #83). Findings included: 1. Resident #10 was admitted to the facility on 09/02/22 with multiple diagnoses that included anxiety disorder and depression. a. Review of an undated North Carolina Medicaid Uniform Screening Tool (NC MUST) inquiry document revealed Resident #10 had a time-limited Level II PASRR with an effective date of 09/02/22 and expiration date of 10/02/22. The admission MDS assessment dated 09/09/22 indicated Resident #10 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. b. Review of an undated NC MUST inquiry document revealed Resident #10 was re-evaluated on 02/06/23 by PASRR due to a change of condition and issued a new Level II PASRR effective 02/09/23 with no expiration date. The significant change MDS assessment dated 03/20/23 indicated Resident #10 was not currently considered by the state Level II PASRR	F 641	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. MDS Coordinator corrected the MDS assessments for residents #10, #26, and #83 and re-submitted on 11/1/23. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Social Worker audited PASRR's on 11/17/23 no additional findings were identified. MDS Coordinator conducted audit of wandering residents MDS's on 11/22/23, no additional findings were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Regional MDS Coordinator will educate Social Worker and MDS Coordinator on 11/29/23 regarding proper coding of MDS assessments to ensure accuracy of assessments. New hires will be educated on hire. 4. Indicate how the facility plans to monitor its performance to make sure that	

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F 641	Continued From page 9 process to have a serious mental illness and/or intellectual disability or other related conditions. During an interview 11/01/23 at 2:59 PM, the MDS Coordinator revealed she completed the section related to Level II PASRR on MDS assessments and confirmed that Resident #10 had a Level II PASRR. The MDS Coordinator stated it was an oversight on her part that Resident #10's MDS assessments dated 09/09/22 and 03/20/23 did not accurately reflect she had a Level II PASRR and modifications would be submitted. During an interview on 11/01/23 at 6:16 PM, the Administrator stated it was his expectation for MDS assessments to be completed accurately. 2. Resident #26 was admitted to the facility 02/08/19 with multiple diagnoses including anxiety disorder and depression. Review of an undated North Carolina Medicaid Screening Tool (NC MUST) inquiry document revealed Resident #26 had a time-limited Level II Preadmission Screening and Resident Review (PASRR) with an effective date of 09/09/20 and expiration date of 06/27/21. Review of an undated NC MUST inquiry document revealed Resident #26 was re-evaluated due to a change in condition and issued a new Level II PASRR effective 06/28/21 with no expiration date. The annual Minimum Data Set (MDS) dated 05/26/23 indicated Resident #26 was not considered by the state Level II Preadmission Screening and Resident Review (PASRR)	F 641	solutions are sustained. Regional MDS Coordinator and or their designee will complete 5 audits per week for 12 weeks on MDS's beginning week of 11/27/23 to ensure proper coding of MDS's. These audits will be reviewed with the Administrator and MDS Coordinator with the results of the monitoring reported to the QAPI committee for review and recommendation for a minimum of three months. Completion Date: 11/29/23	

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process to have serious mental illness and/or intellectual disability or a related condition.

During an interview 11/01/23 at 2:59 PM, the MDS Coordinator revealed she completed the section related to Level II PASRR on MDS assessments and confirmed that Resident #26 had a Level II PASRR. The MDS Coordinator stated it was an oversight on her part that Resident #26's MDS assessment dated 05/26/23 did not accurately reflect she had a Level II PASRR.

During an interview on 11/01/23 at 6:16 PM, the Administrator stated it was his expectation for MDS assessments to be completed accurately.

3. Resident #83 was admitted to the facility 08/28/23 with multiple diagnoses including non-Alzheimer's dementia and heart failure.

Review of Resident #83's behavior care plan last updated 09/11/23 revealed she wandered and at risk for elopement. Interventions included placing Resident #83 in a room close to the nurse's station and utilizing distractions to decrease wandering.

The quarterly Minimum Data Set (MDS) dated 09/27/23 did not reflect Resident #83 had wandering behavior during the lookback period.

In an interview with the Social Worker (SW) on 11/01/23 at 3:13 PM she confirmed she coded Section E on Resident #83's quarterly MDS dated 09/27/23. She stated it was her understanding if a behavior was care-planned, it did not have to be coded on the MDS.

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F 641	Continued From page 11 In a follow-up interview with the SW on 11/01/23 at 4:12 PM she confirmed Resident #83 had wandering behavior during the lookback period. She stated she misunderstood coding guidelines for behavior and the MDS dated 09/27/23 should have reflected that Resident #83 had wandering behaviors. In an interview with the Administrator on 11/01/23 at 6:16 PM he stated it was his expectation MDS assessments be completed accurately.	F 641		
F 761 SS=D	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 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	F 761		11/29/23

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F 761

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be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations, and interviews with staff, the facility failed to secure medicated creams that were in clear view at the bedside for 3 of 4 residents reviewed for medication storage (Resident #37, Resident #9, and Resident #57).

Findings included:

1. Resident #37 was admitted to the facility on 01/26/22. Her current diagnoses included dementia and arthritis.

The annual Minimum Data Set dated 09/04/23 revealed Resident #37's cognition was assessed as severely impaired.

Review of Resident #37's physician orders revealed no current order for the use of a triad hydrophilic wound dressing cream. A standing physician's order was in place for the use of a moisture barrier cream and included directions to apply for 7 days.

During observations on 10/29/23 at 1:58 PM and 10/31/23 at 11:03 AM in the room of Resident #37, in clear view on top of the nightstand were two tubes of medicated cream. One 2.5-ounce tube labeled triad hydrophilic wound dressing cream that included the active ingredient zinc oxide and one 5-ounce tube labeled moisture barrier cream with the active ingredient 12% zinc oxide.

An observation and interview were conducted on 11/01/23 at 4:49 PM with the Director of Nursing

F 761

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 11/1/23 medications were removed form Residents #37, #9, and #57 and properly stored in the medication cart.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

To identify other residents with this same issue on 11/17/23 the Director of Nursing or designee conducted a room sweep of all resident rooms to ensure there were no other residents with medications not stored properly at bedside. Any medication found were removed from the resident's room and placed in the medication cart.

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

To prevent this from recurring on 11/17/23 the Director of Nursing or designee educated all licensed nurses on the expectations of the proper location of drug storage. All newly hired licensed nurses and agency nurses will receive this same education prior to working with residents.

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F 761	Continued From page 13 (DON). The DON observed both tubes of the medicated cream on the top of the nightstand and explained those could not be kept in the room of Resident #37. She revealed standing orders were in place for the use of the moisture barrier cream and it was kept on the treatment cart and applied by the nurse and for the use of triad hydrophilic wound dressing cream a physician order would need to be in place and the cream applied by the nurse and kept on the treatment cart. During an interview on 11/01/23 at 5:43 PM the DON stated it was ultimately her responsibility to follow up on medications by doing random spot checks of resident rooms. She further stated the nurses should check resident rooms for medications at the bedside. 2. Resident #9 was admitted to the facility 02/11/20 with diagnoses including heart failure and quadriplegia (paralysis that affects all four limbs). The annual Minimum Data Set (MDS) dated 10/11/23 revealed Resident #9 was cognitively intact. Review of Resident #9's physician orders revealed no current order for the use of zinc oxide cream. During observations on 10/29/23 at 12:42 PM, 10/20/23 at 8:27 AM, 10/31/23 at 8:46 AM, and 11/01/23 at 8:14 AM, in clear view on top of a shelf in Resident #9's room was a 15-ounce container of medicated cream with the active ingredient 25% zinc oxide. An interview with Resident #9 on 10/29/23 at	F 761	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and/or their designee will audit 10 resident rooms weekly for 12 weeks beginning 11/24/23 to ensure no medications are left at bedside and are properly stored. To monitor and maintain ongoing compliance beginning 11/20/23 the Director of Nursing or designee will conduct 10 resident room sweeps for mediations improperly stored for 12 weeks. The results of these audits will be forwarded to the QAPI committee for further review and recommendations. Administrator is responsible for compliance. Completion Date: 11/29/23	

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12:43 PM revealed the zinc cream was applied by staff but had not been applied for "a while".

An observation and interview were conducted on 11/01/23 at 4:22 PM with the Director of Nursing (DON). The DON observed the medicated cream on the shelf and explained it could not be kept in Resident #9's room. She stated a physician order would need to be in place for the use of zinc oxide cream and the cream should be applied by the nurse and kept on the treatment cart.

In a follow-up interview with the DON on 11/01/23 at 5:43 PM she stated it was ultimately her responsibility to follow up on medications by doing random spot checks of resident rooms. She also stated nurses should check resident rooms for medications left at the bedside.

3. Resident #57 was admitted to the facility 12/28/21 with diagnoses including diabetes and muscle weakness.

The quarterly Minimum Data Set (MDS) dated 09/11/23 revealed Resident #57 was cognitively intact.

Review of Resident #57's physician orders revealed no current order for the use of antifungal cream.

Observations on 11/01/23 at 8:14 AM and 11/01/23 at 3:55 PM in clear view on top of Resident #57's dresser was a tube of antifungal cream with the active ingredient 2% miconazole nitrate.

An interview with Resident #57 on 11/01/23 at 8:15 AM revealed staff applied the antifungal

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F 761	Continued From page 15 cream after he used the bathroom. An observation and interview conducted on 11/01/23 at 4:22 PM with the Director of Nursing (DON). The DON observed the medicated cream on the shelf and explained it could not be kept in Resident #57's room. She stated a physician order would need to be in place for the use of antifungal cream and the cream should be applied by the nurse and kept on the treatment cart. In a follow-up interview with the DON on 11/01/23 at 5:43 PM she stated it was ultimately her responsibility to follow up on medications by doing random spot checks of resident rooms. She also stated nurses should check resident rooms for medications left at the bedside.	F 761		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		11/29/23

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§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on a lunch meal tray line observation, record review, and staff interviews the facility failed to serve correct portions of food according to the planned menus. This failure had the potential to affect 61 residents receiving a regular diet texture and 6 residents receiving a pureed diet texture.

Findings included:

1. The menu for the lunch meal on 10/31/23 for residents receiving a regular texture diet was 2 ounces of baked chicken, a half-cup of au-gratin potatoes, and a half-cup of mixed vegetables.

A continuous observation of the lunch meal tray line on 10/31/23 from 12:00 PM through 12:55 PM revealed Cook #2 began plating food and used tongs to place a mixture of bone-in and boneless chicken thighs for residents receiving a regular diet texture. There was no consistent size to the pieces of chicken thighs being served.

In an interview with the Dietary Manager on 10/31/23 at 12:05 PM she confirmed the chicken being served at the lunch meal was a mixture of boneless and bone-in chicken thighs. When the surveyor asked her how she could verify

F 803

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Identified issues with portion sizes on 10/31/23 were immediately corrected by the dietary manager so that the residents receiving regular and pureed menu items were receiving the proper portion size.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected. The Administrator completed audits of meals on 11/3/23 Lunch, 11/6/23 Breakfast and Dinner. The portion sizes were correct with regards to proper scoops as well as utilization of to the portion scale, menu guides were available and utilized by the cooks, portion chart was poste and utilized by the cook,audit did not reveal any additional issues. The Dietary Manager educated staff on 11/1/23 on proper portion sizes and utilizing the diet guides.

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F 803 Continued From page 17
residents were receiving the correct portion size, she stated she could not because she did not have a working scale.

In an interview with the Registered Dietician (RD) on 10/31/23 at 1:20 PM she confirmed there was no way to accurately ensure residents receiving a regular diet texture were getting the correct portion size according to the menu without weighing the chicken, but the plates looked like they contained at least two ounces of chicken. She stated she expected menu portion sizes to be followed.

An interview with Cook #2 on 10/31/23 at 2:08 PM revealed the diet spreadsheet contained information on portion size and residents receiving a regular diet should have received two ounces of chicken. She stated she was instructed by the Dietary Manager to mix boneless and bone-in chicken thighs for the lunch meal and without a scale she was not able to ensure residents received the correct portion size. Cook #2 stated she tried to look through the pieces of chicken and if a piece appeared small, she plated 2 pieces of chicken.

A follow-up interview with the Dietary Manager on 11/01/23 at 9:02 AM revealed she expected dietary staff to follow portion sizes as directed by the menu.

An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected dietary staff to follow menu portion sizes.

2. The menu for the lunch meal on 10/31/23 for residents receiving a regular texture diet was 2 ounces of baked chicken, a half-cup of au-gratin

F 803

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

On 11/13/23 and again on 11/29/23 the Administrator educated the Dietary Manager and Dietary Staff on policies and procedures for ensuring proper portion sizes, utilizing the portion scale, proper scoop sizes (utilizing the portion chart which shows scoop sizes), as well as following the menu guides available and followed when preparing and serving meals. On 11/4/23 Dietary Manager posted portion size chart on the tray line for the cooks to utilize for proper portion sizes. New hires will be educated on hire. IDT team will complete a random review of portion size checks during assistance with meal delivery and report any concerns to the Dietary Manager.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Administrator and/or designee will audit portion sizes beginning on 11/16/23 on tray line 5 times per week for 12 weeks to ensure proper portion sizes for food items are utilized.

The Administrator will report the results of the monitoring to the QAPI Committee for review and recommendation for 12 weeks.

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F 803	Continued From page 18 potatoes, and a half-cup of mixed vegetables. A continuous observation of the lunch meal tray line on 10/31/23 from 12:00 PM through 12:55 PM revealed Cook #2 began plating au-gratin potatoes for residents receiving a regular diet using a number 12 scoop. In an interview with the Dietary Manager on 10/31/23 at 12:05 PM she confirmed the au-gratin potatoes were to be served in a half-cup portion and was not sure if Cook #2 was using the correct sized scoop because she could not locate the diet spreadsheet. In an interview with the Registered Dietician (RD) on 10/31/23 at 1:20 PM she confirmed residents receiving a regular diet texture were to receive half-cup portions of au-gratin potatoes. She stated Cook #2 used a number 12 scoop which contained one-third of a cup of au-gratin potatoes and she should have used a number 8 scoop, which contained a half-cup portion. She stated she expected menu portion sizes to be followed. An interview with Cook #2 on 10/31/23 at 2:08 PM revealed the diet spreadsheet contained information on portion size and residents receiving a regular diet should have received a half-cup portion of au-gratin potatoes. She stated she was instructed by the Dietary Manager to use the number 12 scoop instead of the number 8 scoop for au-gratin potatoes served at the lunch meal. A follow-up interview with the Dietary Manager on 11/01/23 at 9:02 AM revealed she expected dietary staff to follow portion sizes as directed by the menu.	F 803	Completion Date: 11/29/23	

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An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected dietary staff to follow menu portion sizes.

3. The lunch menu for residents receiving a pureed diet texture on 10/31/23 was 3.25-ounces of chicken, a half-cup portion of au-gratin potatoes, and a 3.25-ounce portion of green beans.

A continuous observation of the lunch meal tray line on 10/31/23 from 12:00 PM through 12:55 PM revealed Cook #2 began plating chicken and mixed vegetables for residents receiving a pureed diet using a number 12 scoop for both food items.

In an interview with the Dietary Manager on 10/31/23 at 12:05 PM she stated mixed vegetables were substituted for green beans for residents receiving a pureed diet. She stated she was not sure if Cook #2 was using the correct sized scoop to serve pureed chicken and mixed vegetables because she could not locate the diet spreadsheet.

In an interview with the Registered Dietician (RD) on 10/31/23 at 1:20 PM she confirmed residents receiving a pureed diet texture were to receive a 3.25-ounce portion of chicken and a 3.25-ounce portion of mixed vegetables. She stated Cook #2 used a number 12 scoop which contained 2.8-ounces of chicken and 2.8-ounces of mixed vegetables and she should have used a number 10 scoop for the chicken and a number 10 scoop for the mixed vegetables. She stated she expected menu portion sizes to be followed.

An interview with Cook #2 on 10/31/23 at 2:08

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F 803	Continued From page 20 PM revealed the diet spreadsheet contained information on portion size and residents receiving a pureed diet should have received a 3.25-ounces of chicken and 3.25-ounces of mixed vegetables. She stated she was instructed by the Dietary Manager to use the number 12 scoop instead of a number 10 scoop to plate the chicken and mixed vegetables served at the lunch meal. A follow-up interview with the Dietary Manager on 11/01/23 at 9:02 AM revealed she expected dietary staff to follow portion sizes as directed by the menu. An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected dietary staff to follow menu portion sizes.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		11/29/23

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F 812	Continued From page 21 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean floor and walls and label and date food and beverage items in 1 of 1 walk-in cooler; maintain a clean floor, cover food, and store food items off the floor for 1 of 1 walk-in freezer; date food items, store food off the floor, and remove expired food in 1 of 1 dry goods storage room; maintain clean stove, oven, shelves, and floor in 1 of 1 kitchen; cover, label, and date open beverage and food items, discard food with signs of spoilage, and maintain a clean reach-in cooler for 1 of 1 reach-in cooler; cover, label, and date food items and maintain a clean reach-in freezer for 1 of 1 reach-in freezer; restrain facial hair during food preparation; maintain 1 of 1 garbage disposal in working order; and ensure food items were labeled and dated in 1 of 2 nourishment rooms (A/B hall). Findings included: 1. An initial tour of the walk-in cooler on 10/29/23 at 10:27 AM revealed the following: (a). multiple dried brown stains were observed on the floor and multiple areas of a black/brown substance to all walls of the cooler (b). an opened and undated 46-ounce bottle of vegetable juice sitting on a shelf in the cooler (c). a tray containing 11 bowls of undated dessert sitting on a shelf An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed all food and beverage items should be labeled and dated	F 812	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Immediate actions were taken to discard expired and/or unlabeled/undated food items and place items that were on the floor onto the shelving, clean coolers/freezers and other kitchen equipment. Staff member immediately donned a beard net. Garbage disposal that was leaking was repaired on 11/20/23. 2. All residents have the potential to be affected. The Administrator performed and audit of the refrigerators/freezer, kitchen equipment and storage room on 11/2/23 no issues were identified. Audit performed by Administrator on remaining staff for hair restraints on 11/2/23, no issues were identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Administrator educated the Dietary Manager and Dietary Staff 11/20/23 and again on 11/29/23 on policies and procedures for labeling opened food items, proper storage of food items, proper sanitation of the kitchen	

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F 812	Continued From page 22 when opened and it was everyone's job to label and date items when placing them in the cooler. She stated she was short a staff member in a prep position and that person would normally be responsible for ensuring all food and beverages were labeled and dated. The Dietary Manager stated there was not a regular cleaning schedule for cleaning the cooler, but it was cleaner than it was when she began employment at the end of June 2023. An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected the cooler to be clean and free of debris and for all food and beverage items to be labeled and dated. 2. An initial tour of the walk-in freezer on 10/29/23 at 10:31 AM revealed the following: (a). scattered debris on the floor of the freezer (b). a 5-pound tube of ground beef was sitting on the floor of the freezer under a shelf. (c). an undated 10-pound box of sausage was partially open to air and the exposed sausage was dried out (d). a box of sweet potatoes, ground beef patties, potato portions, and french fries was sitting on the floor of the freezer An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed all food items should be labeled, dated, and covered when opened and it was everyone's job to label and date items when placing them in the freezer and discard food items that showed signs of spoilage. She stated she was short a staff member in a prep position and that person would normally be responsible for ensuring all food items were labeled, dated, and covered. The Dietary	F 812	equipment, and proper use of hair restraints, proper cleaning of floors and walls in the kitchen and walk-in cooler/freezer, and cleaning of coolers/freezers. Dietary Manager was educated on 11/20/23 by the Administrator on how to identify soiled or unsanitary kitchen equipment and identifying physical plant issues and appropriately requesting a maintenance work order. On 11/29/23 Dietary Manager updated the cleaning schedules to ensure proper cleaning and sanitation of equipment, kitchen floors/walls and coolers/freezers, there schedules were reviewed with dietary staff on 11/29/23. On 11/22/23 Administrator and/or designee educated 100% of nursing and housekeeping staff on storage of food items, labeling of food items and discarding of unlabeled/expired food items in nourishment rooms. IDT staff will observe nourishment areas for compliance and report any negative findings to the appropriate department head. New hires will be educated upon hire. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator and/or designee will audit the dietary department and nourishment areas 5 times per week for 12 weeks beginning 11/20/23 to ensure propter food storage, hair restraints and kitchen sanitation. The Administrator or Maintenance Director will audit kitchen 5 weekly for 12 weeks beginning 11/24/23	

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F 812	Continued From page 23 Manager stated there was not a regular cleaning schedule for cleaning the freezer, but it was cleaner than it was when she began employment at the end of June 2023. She stated the last food delivery was on 10/27/23 and she was not sure why there were food items on the floor. The Dietary Manager confirmed that no food items should be stored on the floor. An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected the freezer to be clean and free of debris, all food items should be covered or discarded if they showed signs of spoilage, and no food items should be stored on the floor. 3. An initial tour of the dry storage room on 10/29/23 at 10:34 AM revealed the following: (a). 2 boxes of salad dressing, 2 boxes of vegetable oil, a box of instant potatoes, peanut butter, hot cocoa, and grits were sitting directly on the floor (b). 3 bags of opened but undated pasta (c). 2 packs of 24 count flour tortillas with a best by date of 10/24/23 (d). 8 packs of 12 count flour tortillas with a best by date of 09/05/23 An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed all food items should be dated when opened and it was everyone's responsibility to date food when it was opened. She stated the last food delivery was 10/27/23 and she was not sure why food items were stored on the floor. The Dietary Manager confirmed that no food items should be stored on the floor. She confirmed food should be used or discarded on or before the best by date and all	F 812	to ensure there are no physical plant issues. The Administrator will report the results of the monitoring to the QAPI committee for review and recommendation for a minimum of three months. Completion Date: 11/29/23	

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staff should be checking for expired food.

An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected all opened food items to be dated, expired food to be used or discarded on or before the best by date, and no food items should be stored on the floor.

4. An observation of the kitchen on 10/29/23 at 10:40 AM revealed scattered debris and multiple areas of dried black substance to the floor, a thick dried layer of black debris to the stove, multiple dried splatters to the bottom shelf of a table, and multiple areas of dried debris to the oven door.

An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed the kitchen floor, stove, shelf, and oven should be clean and free of debris but it was cleaner than it was when she began employment at the end of June 2023. She stated there was not a cleaning schedule and she had not been able to do as much cleaning as she would like due to having to frequently work as a cook or a dietary aide.

An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected the kitchen floors, stove, oven, and shelf to be clean and free of debris.

5. An observation of the reach-in cooler on 10/29/23 at 11:00 AM revealed the following:

(a). an undated packet of sliced turkey that was open to air
(b). an opened and undated container of butter
(c). an undated container of chopped lettuce with multiple brown areas to the lettuce
(d). an opened and undated 33.8-ounce bottle of

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water
(e). multiple scattered areas of dried debris to cooler doors

An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed all food and beverage items should be labeled and dated when opened and it was everyone's job to label and date items when placing them in the cooler and discard food items that showed signs of spoilage. She stated she was short a staff member in a prep position and that person would normally be responsible for ensuring all food and beverages were labeled, dated, and covered. The Dietary Manager stated there was not a regular cleaning schedule for wiping down the outside of the cooler, but it was cleaner than it was when she began employment at the end of June 2023.

An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected all food items to be labeled and dated, no food items should be left open to air, food should be used or discarded before showing signs of spoilage, and the cooler should be clean and free of debris.

6. An observation of the reach-in freezer on 10/29/23 at 11:05 AM revealed the following:

(a). an undated bag of hashbrowns open to air that were dried out
(b). an undated box of biscuits open to air
(c). 2 bags of english muffins with ice crystals
(d). an open and undated bag of omelets
(e). multiple scattered areas of dried debris to freezer doors

An interview with the Dietary Manager on

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F 812	Continued From page 26 10/29/23 at 2:05 PM revealed all food and beverage items should be labeled and dated when opened and it was everyone's job to label and date items when placing them in the cooler and discard food items that showed signs of spoilage. She confirmed food should not be left open to air and the english muffins should have been discarded due to being freezer-burned. She stated she was short a staff member in a prep position and that person would normally be responsible for ensuring all food and beverages were labeled, dated, and covered. The Dietary Manager stated there was not a regular cleaning schedule for wiping down the outside of the freezer, but it was cleaner than it was when she began employment at the end of June 2023. An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected food to be dated when opened, food should not be left open to air, food with freezer-burn should be discarded, and the freezer should be clean and free of debris. 7. An observation of Cook #1 on 10/29/23 at 11:10 AM revealed he was slicing tomatoes and did not have a restraint in place to cover his facial hair. In an interview with Cook #1 on 10/29/23 at 11:10 AM he confirmed he was not wearing a restraint for his facial hair and stated he was not sure if the kitchen stocked restraints for facial hair. An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed the kitchen did have facial hair restraints and they were in her office, but staff probably did not know where they were. She stated facial hair should be restrained any time food was being prepared or served.	F 812		

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An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected staff to restrain facial hair when in the kitchen.

8. An observation of the garbage disposal on 10/29/23 at 11:15 AM revealed a dish pan sitting beneath the disposal filled approximately three fourths of the way with brown water.

An interview with the Dietary Manager on 10/29/23 at 2:05 PM revealed the garbage disposal was leaking and the dish pan was in place to collect drainage. She stated the garbage disposal had been leaking since she began employment at the end of June 2023 and maintenance was waiting for a part to arrive to fix the disposal.

An interview with the Maintenance Director on 11/01/23 at 3:50 PM revealed he had fixed the garbage disposal periodically in the past, but he was not aware of the garbage disposal currently having a leak. He stated he relied on dietary staff to notify him of any equipment that was in need of repair.

An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected dietary staff to notify maintenance if there were any kitchen items that needed repair.

8. An observation of the A/B hall nourishment room refrigerator on 10/29/23 at 2:30 PM revealed there was an opened and undated bowl of soup and an undated and unlabeled bowl of unidentifiable leftover food.

An interview with the Dietary Manager on

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F 812	Continued From page 28 10/29/23 at 2:30 PM revealed she was not sure who was responsible for checking the refrigerator for unlabeled and undated food or discarding food that wasn't labeled or dated. An interview with the Administrator on 11/01/23 at 6:16 PM revealed he expected dietary staff to check nourishment rooms daily for unlabeled and undated food items.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		11/29/23

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and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

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

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

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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on

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high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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

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

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of

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F 867	Continued From page 31 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, 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 investigation survey completed on 05/12/22. This was for one repeat deficiency originally cited in the area of food procurement-store/prepare/serve that was subsequently recited on the current recertification and complaint investigation survey of 11/01/23. 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: F 812: Based on observations and staff interviews the facility failed to maintain a clean floor and walls and label and date food and beverage items in 1 of 1 walk-in cooler; maintain a clean floor, cover food, and store food items off the floor for 1 of 1 walk-in freezer; date food items, store food off the floor, and remove expired food in 1 of 1 dry goods storage room; maintain clean stove, oven, shelves, and floor in 1 of 1 kitchen; cover, label, and date open beverage and food items, discard food with signs	F 867	The Quality Assurance Process was re-evaluated by the Administrator and Director of Nursing on 11/20/23 including monitoring of F-812. The Administrator and the Director of Nursing reviewed the Federal Regulation for F-867 QAPI/QAA Improvement Activities and policy and procedure for QAPI. On 11/20/23 the Administrator and Director of Nursing reviewed the QA minutes and QA audits from 5/12/22 to present to identify any additional monitoring. It was determined that the issue related to management turnover within the dietary department. Administrator or designee will audit dietary department for sanitation and food storage 5 times per week for 12 weeks and periodically thereafter to ensure continued compliance. On 11/22/23 the Administrator and Director of Nursing were re-educated by the Regional Vice President of Operations related to the requirements of F-867. The RVPO and/or designee will complete a QAPI Audit Tool monthly for a minimum of three months beginning November 2023 to ensure systems and processes continue to be monitored and the	

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F 867	Continued From page 32 of spoilage, and maintain a clean reach-in cooler for 1 of 1 reach-in cooler; cover, label, and date food items and maintain a clean reach-in freezer for 1 of 1 reach-in freezer; restrain facial hair during food preparation; maintain 1 of 1 garbage disposal in working order; and ensure food items were labeled and dated in 1 of 2 nourishment rooms (A/B hall). During the recertification and complaint investigation survey of 05/12/22, the facility failed to label or date food items stored in the refrigerator, discard expired food items, ensure frozen food was kept solid, and store food items away from soiled surfaces. An interview with the Administrator on 11/01/23 at 6:41 PM revealed that the breakdown with the kitchen was the turnover with the Certified Dietary Manager (CDM). The Administrator further revealed that steady leadership was the key to a successful kitchen and dining experience. He stated the facility had a plan in place that included rebuilding the entire department from scratch. He stated that that this is an issue they will continue to discuss in their monthly Quality Assurance and Performance Improvement (QAPI) meetings.	F 867	follow-up completed as required. Results of the audit will be brought to the QAPI meeting by the Administrator for review. If any discrepancies are noted, further action will be implemented by the Administrator. Completion Date: 11/29/23	