STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345570	A. BUILDING _____ B. WING _____	C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERSVILLE HEALTH & REHAB CENTER	13835 BOREN STREET HUNTERSVILLE, NC 28078

(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 were conducted on 1/22/24 through 1/25/24. The facilty was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # ZMUH11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey were conducted on 1/22/24 through 1/25/24. Event ID # ZMUH11. The following intakes were investigated NC00209454, NC00209822, NC00209890. 5 of 5 allegations did not result in a deficiency.	F 000		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §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; This REQUIREMENT is not met as evidenced by: Based on observations, a resident interview, staff interviews and record review, the facility failed to honor food preferences for 1 of 3 sampled residents reviewed for food preferences (Resident #281). The findings included:	F 806	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the	2/22/24

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

Electronically Signed | 02/09/2024

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F 806	Continued From page 1 Resident #281 was admitted to the facility on 1/16/24. Diagnoses included type 2 diabetes mellitus, iron deficiency anemia, gastroesophageal reflux disease and lipoprotein deficiency, among others. An admission Minimum Data Set assessment dated 1/20/24 (in progress) indicated her cognition was intact, she had clear speech, able to understand and be understood, required set up/clean up assistance with meals and no weight loss/gain. A care plan revised 1/22/24 identified Resident #281 was at risk for nutritional decline related to a recent hospitalization, adjustment to a new environment, and diagnoses. Interventions included encouraging good food intake, recording the percentage of food eaten, and reviewing food preferences with the resident as needed. Food intake records from 1/17/24 - 1/24/24 documented that Resident #281 ate an average of 51 - 75% of her meals provided by the facility. Resident #281 was interviewed and observed in her room on 1/22/24 at 11:15 AM, during the interview, she expressed that her food requests were not honored. Resident #281 stated that when she completed the menu to request her meal preferences for the next day's meals, she rarely received food according to the menu she completed. She stated that when staff came to pick up her meal tray after the meal, they did not offer an alternate when she expressed that she did not receive her preferences, staff just removed her meal tray.	F 806	date or dates indicated. F806 1. Resident #281 stated that her dietary preferences were not being honored 2. Current residents are at risk 3. On 1/24/2024, the dietary Manager met with resident # 281 and updated her preferences. An audit of current patients was completed on 1/24/2024 to ensure that all preferences were updated by 1/24/2024 Education was provided to the current dietary staff by the dietary manager on 1/25/2024. Education included to ensure that residents preferences are met. Dietary aides are to check with the main kitchen and supplies are low in the kitchenettes. Education was provided to current certified nursing assistants by Staff Development Coordinator on 2/08/2024. Education included to ensure tray tickets and trays are accurate. Dietary aides and certified nursing assistants will not be allowed to work until education is received. New Dietary aides and certified nursing assistants will receive education during the orientation process. 4. The dietary manager will interview 5 patients daily x 4 weeks, then 5 patients weekly x 4 weeks, then 5 patients monthly x 1 month.	

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F 806	Continued From page 2 Resident #281 was observed with her lunch meal and interviewed on 1/24/24 at 12:00 PM. Resident #281 received spaghetti with meat sauce, garlic bread, orange sherbet, and lemonade. The lunch meal tray card on her meal tray revealed buttered egg noodles were also circled as a request. Resident #281 stated that when she completed her menu for the lunch meal for 1/24/24, she circled buttered egg noodles and wrote corn on her menu to give herself some additional items she could eat in case she did not like the spaghetti. Resident #281 stated she did not receive the buttered egg noodles or the corn. Resident #281 stated she wanted the egg noodles and the corn, but when she asked staff about those items, she was told it was not available. Resident #281 stated "I don't receive my preferences 90% of the time and when I ask, staff say, we are out of that." Resident #281 stated that last week she completed her menu and asked for salad dressing, but she received a salad with no dressing, so she used a pack of dressing she brought from the hospital. The Dietary Manager (DM) was interviewed on 1/24/24 at 1:56 PM. He stated that the residents were given a menu to complete each day to select the food items they want to eat and that the tray card for each meal was based on the resident's food preferences that were obtained on admission. He stated that if a resident wrote in a request on the menu they received, and it was available, the dietary staff would prepare it for the resident. He stated that dietary staff provided the menus daily between 3 PM - 4 PM and picked up the completed menus from nursing staff around 6 AM the next morning. He stated that the menu tickets were discarded daily so he did not have them available for review. The DM stated he	F 806	5. The Dietary manager will provide Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. The Director of Nursing and Administrator are responsible for implementing and maintaining an acceptable plan of correction. Date of completion 2/22/2024	

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F 806	Continued From page 3	F 806		

could not explain why Resident #281 did not receive the items per her preference (buttered egg noodles, corn, salad dressing) because those items were available.

An interview with dietary aide (DA) #1 occurred on 1/25/24 at 12:40 PM. DA #1 stated she plated the lunch meal on the unit where Resident #281 resided. DA #1 stated she did not provide buttered egg noodles or corn to Resident #281 for lunch on 1/24/24 because she did not have them available to serve. DA #1 stated that she had the pasta that was served with the spaghetti so that's what she served Resident #281. She stated mixed vegetables were also available, but that she did not offer Resident #281 a substitute for the corn.

A follow up interview with the DM occurred on 1/25/24 at 1:43 PM. He stated that the DA should have called the kitchen to notify him if there were food items that residents requested but she did not have available once she got on the unit to serve. The DM stated the foods Resident #281 requested were available and had he been notified; he would have made sure those items were provided.

A phone interview with the Registered Dietitian (RD) occurred on 1/25/24 at 3:40 PM. The RD stated that the DA should go to the kitchen to get any food requested by a resident if those foods were available. The RD stated that she expected the DM to follow up on any food concerns that were brought to his attention regarding honoring resident food preferences.

The Administrator stated in an interview on 1/25/24 at 2:18 PM that the facility should honor

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F 806	Continued From page 4 resident food preferences or let the resident know if the request was something that the facility did not have and then try to accommodate the request with something comparable.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to remove expired food items, date open and perishable foods stored in 1 of 1 reach-in cooler and 1 of 1 walk-in freezer and ensure steamer pans were not stacked wet for 1 of 2 kitchen observations. These practices had the potential to affect food served to residents. The findings included:	F 812	F812 1. Expired food from 1/21/2024 were not removed and steamer pans were stacked wet 2. Current residents are at risk 3. On Monday 1/22/2024, the dietary manager removed all expired items from Sunday 1/21/24 and unstacked the steamer pans. The regional dietary manager completed	2/22/24

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F 812	Continued From page 5 The facility's kitchen was toured on 1/22/2024 at 10:20 AM. An observation was conducted of the reach-in cooler and the following was observed: a. A container of vanilla pudding was noted with a creation date of 3/10 (no year). The expiration date was noted to be 3/14 (no year). b. A container of cantaloupe was noted with an expiration date of 1/21/2024. c. A container of tuna salad was noted with an expiration date of 1/21/2024. d. A container of pineapple pieces was noted without a creation date or expiration date. e. A second container of tuna salad was noted without a creation date or expiration date. f. A container of lettuce salad was noted without a creation date or expiration date. g. A container of shredded cheddar cheese was noted without an open date or expiration date. h. A container of chicken noodle soup was noted without a creation date or expiration date. i. Two trays of various sandwiches were noted to be individually wrapped and no sandwiches had a creation date or expiration date. An observation of the walk-in freezer was conducted 1/22/2024 at 10:30 AM. A bag of chicken meat was noted to be stored open and no open date was on the bag. The dishwashing area was observed on 1/22/2024 at 10:35 AM, and a shelving unit was noted in the drying area. Three steamer pans were noted to be wet with dripping water and were stacked on top of each other and nestled. During the observations, the Dietary Manager (DM) reported that all expired food should have been discarded on 1/21/2024, the food labeled	F 812	a full kitchen audit to ensure that all expired foods were discarded. Audit was completed on 1/22/2024 Education was completed with the dietary team on proper pan drying techniques and the food storage policy on 1/23/2024. Education was provided by the dietary manager. The dietary manager will complete daily rounds to ensure that all expired foods are discarded and to ensure that proper drying practices are being used. The weekend cooks will be assigned to discard any expired food items on the date that food expires. The dietary manager will report any concerns to the regional dietary manager, the administrator, and QAPI team. New Dietary aides and certified nursing assistants will receive education during the orientation process by our dietary manager and/or designee. 4. The dietary manager or designee will complete daily kitchen audits to ensure proper food storage and drying practices 5x/wk x 12 weeks. The regional director manager will complete weekly kitchen audits x4 weeks, then twice a monthly x 4 weeks, then monthly x 1 5. The Dietary manager will provide Results of the audits and they will be reviewed at Quarterly Quality Assurance Meeting for further resolution as needed. The Director of Nursing and Administrator are responsible for implementing and maintaining an acceptable plan of	

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F 812	Continued From page 6	F 812		

with the creation and the expiration date, the bag of chicken should have been closed and labeled, and the clean steamer pans should have been allowed to air dry completely before they were stacked and nestled together. The DM reported no staff had checked on the reach-in cooler or freezer that date.

An interview was conducted with Cook #1 on 1/24/2024 at 12:31 PM. Cook #1 explained he had worked on 1/21/2024 and he had made the trays of sandwiches for the facility on that date. Cook #1 reported he was aware he should have labeled the sandwiches with the creation date and the expiration date, but he had forgotten because he had been busy. Cook #1 explained he did not check the reach-in cooler for expired food on 1/21/2024.

The dietary aide who worked 1/21/2024 was not available for interview.

The DM was interviewed again on 1/25/2024 at 1:29 PM. When asked about the date on the vanilla pudding, the DM reported he thought it was an error in labeling and that the vanilla pudding had not been in the reach-in cooler since March of 2023. The DM explained the dietary aides were responsible for checking the cooler, fridge, and freezer for expired items and he was not certain why the expired food in the reach-in cooler was not discarded, and why the food was not labeled in the reach-in cooler or freezer. The DM reported he thought that staff were rushing to complete their work and did not allow the steamer pans to dry completely before stacking.

The Administrator was interviewed on 1/25/2024 at 3:01 PM. The Administrator reported the

correction.
Date of completion 2/22/2024

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F 812	Continued From page 7 dietary staff should discard expired items, label perishable foods, and allow all dishes to dry before stacking for storage.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		2/22/24

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F 842	Continued From page 8 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on a resident interview, staff interviews and record review, the facility failed to accurately document an allergy (Resident #281) and the amount of nutritional supplement provided during medication administration (Resident #2). This failure occurred for 2 of 2 sampled residents	F 842	F842 1. Resident #281 had an inaccurate allergy documented in her EMR and the amount of nutritional supplement provided during medication administration was not accurately documented in the EMR	

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F 842	Continued From page 9 reviewed for accuracy of the medical record. The findings included: 1. Resident #281 was admitted to the facility from the hospital on 1/16/24. Diagnoses included type 2 diabetes mellitus, and diabetic neuropathy, among others. A hospital discharge summary dated 1/16/24 for Resident #281 recorded she had an allergy to the medication Metformin (used to treat type 2 diabetes mellitus). The January 2024 Medication Administration Record (MAR) for Resident #281 recorded she had an allergy to the medication Metformin. January 2024 Physician (MD) Order Summary recorded a MD order dated 1/17/24 for Metformin HCL (hydrochloride) tablet 500 mg, give 1 tablet by mouth two times a day related to type 2 diabetes mellitus with diabetic neuropathy. A nurse practitioner (NP) progress note dated 1/18/24 recorded Resident #281 had an allergy to the medication Metformin. A care plan revised 1/19/24 recorded Resident #281 had an allergy to Metformin. A MD progress note dated 1/19/24 recorded Resident #281 had an active allergy to Metformin. An admission Minimum Data Set assessment dated 1/20/24 (in progress) indicated her cognition was intact, she had clear speech, and she was able to understand and be understood.	F 842	2. Current residents are at risk 3. On 1/25/24, Resident #281 allergy list was corrected. Nurse #1 and Nurse #2 were educated on the importance of ensuring accurate documentation. This education was completed by the center□s director of nursing on 1/25/24. The director of nursing completed an audit 1/25/24 on current residents to ensure allergies were listed and correct in the electronic medical record. In addition, current nursing staff received education on the importance of accurate documentation by our staff development coordinator on 1/25/24. Any licensed nurse not receiving education will not be able to work until education completed New Licensed nurses will receive education by the staff development coordinator during the orientation process 4. To ensure that allergy listings are accurate and to ensure that nutritional supplements are accurately documented, the director of nursing or designee will audit 10 new admissions a week x 4 weeks, then 10 new admissions monthly, then 5 new admissions monthly. 5. The director of nursing will provide Results of the audits and they will be reviewed at Quarterly Quality Assurance Meeting for further resolution as needed. The Director of Nursing and Administrator are responsible for implementing and maintaining an acceptable plan of correction. Date of completion 2/22/2024	

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F 842	Continued From page 10	F 842		

A NP progress note dated 1/22/24 recorded Resident #281 had an allergy to the medication Metformin. The NP progress note documented the plan for her diagnosis of type 2 diabetes mellitus was to monitor blood glucose levels every twice daily and continue prescription medication management with Metformin HCL 500 mg twice daily.

Resident #281 stated in an interview on 1/25/24 at 12:43 PM that she was not allergic to the medication Metformin and that she took the medication at home with no problems. She stated that the NP asked her about continuing the medication while she was at the facility, and she told the NP she was not allergic, so the NP ordered it. Resident #281 stated that she did not know where that the documentation came from indicating that she was allergic to Metformin.

The Director of Nursing (DON) stated in an interview on 1/23/24 at 1:02 PM that documentation of allergies was obtained from the hospital discharge summary and from pre-admission records. The DON stated Resident #281 was admitted from the hospital and reviewed her hospital discharge summary during the interview. The DON stated that the allergy to Metformin was recorded in the hospital discharge summary which was given to the MD/NP for review. The DON stated that the NP reviewed the hospital discharge summary for Resident #281, recorded in her progress note to continue the Metformin and wrote an order for it.

The NP stated in an interview on 1/23/24 at 1:21 PM that she spoke to Resident #281 about the allergy to Metformin that was recorded in her hospital discharge summary because the hospital

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F 842	Continued From page 11	F 842		

discharge summary indicated Metformin was a medication she took at home prior to the hospitalization. The NP said that Resident #281 said she was not allergic to Metformin and that she wanted to continue taking the medication while she received therapy at the facility, so the NP wrote the order. The NP stated she should have advised nursing staff to remove the allergy from her medical record and stated, "Metformin needs to be removed from her medical record as an allergy for this patient."

2. Resident #2 was admitted to the facility on 12/27/23. Diagnoses included dysphagia, elevated body mass index, vascular dementia with psychosis, mood disturbance and anxiety, among others.

A progress note dated 1/22/24 by the Registered Dietitian (RD) recorded a recommendation to add a high calorie no sugar added nutritional supplement of 90 milliliters (ml) twice daily for additional calories and to prevent further weight loss.

The January 2024 Medication Administration Record (MAR) for Resident #2 recorded to provide 90 ml of a high calorie no sugar added nutritional supplement twice daily. Nurse #1 recorded on the January 2024 MAR for Resident #2 that she provided 237 ml of the supplement at 9 AM and 5 PM on 1/24/24.

An interview with Nurse #1 occurred on 1/25/24 at 12:30 PM. Nurse #1 stated that the MD orders for nutritional supplements kept changing. Nurse #1 stated that she provided Resident #2 with 90 ml of the supplement per the order, but that she documented 237 ml because she used a larger

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F 842	Continued From page 12 cup to provide the supplement. Nurse #1 stated that the documentation of 237 ml was an error. The RD stated in a phone interview on 1/25/24 at 3:37 PM that providing additional calories from a high calorie nutritional supplement to Resident #2 would not be a problem for this Resident due to her history of weight loss, but incorrect documentation of the amount of the nutritional supplement administered could cause a miscalculation of calories received during a nutritional assessment. The Director of Nursing stated on 1/25/24 at 1:30 PM in an interview that the medical record should be documented accurately; the nurse should record the amount of supplement given and should give the amount of nutritional supplement per the MD order.	F 842		
F 867 SS=E	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.	F 867		2/22/24

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F 867	Continued From page 13 §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, 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	F 867		

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F 867	Continued From page 14	F 867		

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 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.

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F 867	Continued From page 15 §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 action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented and effective procedures and monitor the interventions that the committee put into place following a recertification and complaint investigation dated 6/09/22 for one deficiency in the area of dietary services F 812. Also, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented and effective procedures and monitor the interventions that the committee put into place following the complaint survey date 4/10/23 for one deficiency in the area of accurate medical records F 842. These deficiencies were cited during a recertification and complaint survey dated 1/25/24. The continued failure of the facility during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program.	F 867	F867 1. Cross referenced to F 812 and F842 2. Current residents are at risk 3. On 1/26/24, the QAPI committee was made aware of the repeat deficiencies and completed root cause analysis. Based upon interviews with staff, it was determined that the non-compliance was due to new hires not receiving proper education on resident preferences and dietary policies. It was determined that additional education to all staff was needed on repeat deficiencies. It was also determined that this education needs to be completed with all new hires as part of the center's orientation process. Our dietary manager or designee will provide education to all new hires on its policies for resident preferences and food procurement/storage/sanitation during orientation. In reference to F 842, it was determined that the allergies were not	

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F 867	Continued From page 16 Findings included. This tag is cross referenced to: F 812 Based on record reviews and staff interviews, the facility failed to remove expired food items, date open and perishable foods stored in 1 of 1 reach-in cooler and 1 of 1 walk-in freezer and ensure steamer pans were not stacked wet for 1 of 2 kitchen observations. These practices had the potential to affect food served to residents During the recertification and complaint investigation date 6/9/22 the facility failed to date, remove, and/or discard food items stored for use with signs of spoilage, stored past the use by date and/or stored open to air in 1 of 1 walk in cooler, 1 of 1 walk in freezer, and 1 of 1 dry storage area. These practices had the potential to affect residents served this food. F 842 Based on a resident interview, staff interviews and record review, the facility failed to accurately document an allergy (Resident #281) and the amount of nutritional supplement provided during medication administration (Resident #2). This failure occurred for 2 of 2 sampled residents reviewed for accuracy of the medical record. During the complaint investigation date 4/10/23 the facility failed to document in the medical record the effectiveness of pain medication administered. This occurred for 1 of 1 sampled resident reviewed for pharmaceutical services.	F 867	verified with hospital paperwork and resident and was inappropriate listed. An audit was conducted for current resident to ensure that listed allergies were listed correctly. It was determined that the nurse made an error in documenting the correct amount of supplement as a result in the resident requesting additional amount. Current nursing staff was educated on providing correct amount of supplement and documentation of amount given. 4. The QAPI committee will meet monthly x12 to review all plan of corrections and will make recommendations as needed. 5. The regional director of clinical services will attend quarterly QA to ensure compliance. The administrator will report to the governing body and to the vice president of operations any non-compliance and will ensure that auditing of the repeat deficiencies quarterly x4. Date of completion 2/22/2024	

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F 867	Continued From page 17 Interview was conducted with the Administrator on 1/25/24 at 2:45 pm about his repeat tag for the kitchen. He indicated that he expected all citations to be monitored through the center's QAPI program. Any repeat citation would require continuous monitoring through the monthly QAPI meetings until the deficient practice has been resolved. After resolved, the center would continue to monitor the resolved issue through its quarterly QAPI meetings. Education would be completed to ensure staff are aware of expectations and these expectations would be tracked by way of auditing.	F 867		