STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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 10/14/24 through 10/17/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 2YM011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/14/24 through 10/17/24. Event ID# 2YM011. The following intakes were investigated: NC00208406, NC00213822, NC00215540, NC00220053, NC00209731, NC00220493, NC00222565, NC00217194, NC00217962, NC00218034, NC00218140, NC00212573, NC00212568, NC00208400, NC00210217, NC00210804, NC00211066, NC00215999, NC00219082. One (1) of the 56 complaint allegations resulted in a deficiency.	F 000		
F 569 SS=B	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death.	F 569		11/7/24

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

Electronically Signed | 11/07/2024

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F 569	Continued From page 1 Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review of resident trust accounts, the facility failed to convey funds within 30 days and forward the balance of funds to the estate of an expired resident for 2 of 3 residents reviewed for personal funds (Resident #281 and Resident #134). The findings included: 1. Resident #281 was admitted to the facility on 7/12/21 and expired on 7/31/24. Review of the resident trust account for Resident #281 conducted on 10/17/24 revealed a balance of $125. 22 was not conveyed to the resident's estate within 30 days of her death on 7/31/24. An interview was conducted on 10/16/24 at 12:00 PM, in conjunction with a record review with the Financial Counselor who revealed the check had not been sent to the Clerk of Court within the designated 30 days. The Financial Counselor stated that it was not discovered until an audit was done at the end of July 2024 that the funds had not been forwarded to the Clerk of Court. The Financial Counselor further stated after the completion of the audit, the facility did not communicate or correspond with the family that the money in the amount of $125.22 was available or had been forwarded to the Clerk of	F 569	Corrective action for the residents found to be affected by the deficient practice Resident 281□s account was reconciled, and due money was sent to Clerk of Courts for Durham County on 11/6/2024. Resident 134□s account was reconciled, and due money was sent to his spouse on 11/6/2024. Corrective action for other residents having the potential to be affected by the same deficient practice: Full audit of all residents was completed with 84 residents being identified as needing reconciliation of due monies Checks for all 84 residents were mailed on 11/6/2024. Systemic changes made to ensure that the deficient practice will not recur: On 11/5/2024, the Financial Counselor received education regarding expectations for resident account reconciliation upon discharge and how to handle due money payments	

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F 569	Continued From page 2 Court. A telephone interview was conducted on 10/16/24 at 1:15 PM with the former Administrator who stated the Financial Counselors were responsible for ensuring financial records for expired residents were reviewed and audited monthly to ensure all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations within 30 days. An interview was conducted on 10/16/24 at 2:32 PM, in conjunction with a record review with the Area Vice President and the Financial Counselor who stated the facility failed to forward the funds to the Clerk of Court and/or resident representative. The Financial Counselor stated the money should have been sent to the Clerk of Court within 30 days of death per policy. The Area Vice President stated the discrepancy was not discovered until an audit was done at the end of July 2024. The Area Vice President also stated the monies would be sent out immediately. 2. Resident #134 was admitted to the facility on 1/8/16 and expired on 8/29/24. Review of the resident trust account for Resident #134 conducted on 10/16/24 revealed a balance of $2,349.50 was not conveyed to the resident's estate within 30 days of her death on 8/29/24. An interview was conducted on 10/16/24 at 12:00 PM, in conjunction with a record review with the Financial Counselor who revealed the check had not been sent out the check to the Clerk of Court within the designated 30 days. The Financial Counselor stated that it was not discovered until	F 569	The Financial Counselor will review the account of a discharging resident upon discharge to ensure any monies due or accounted for and paid. The Financial Counselor will do an audit of all resident accounts weekly for 4 weeks, then monthly for 3 months for accuracy, reconcile any accounts that are noted to have a refund due to resident and make payment. Plans to monitor its performance to make sure that the solutions are sustained Results of all audit finding will be brought to the attention of Facility Administrator in real-time Results of all audit findings will be reported at QAPI meetings. Date of compliance: 11/7/2024	

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F 569	Continued From page 3 an audit was done at the end of July 2024 that the funds had not been forwarded to the Clerk of Court. The Financial Counselor further stated after the completion of the audit, the facility did not communicate or correspond with the family that the money in the amount of $2,349.50 was available or had been forwarded to the Clerk of Court. A telephone interview was conducted on 10/16/24 at 1:15 PM with the former Administrator who stated the Financial Counselors were responsible for ensuring financial records for expired residents were reviewed and audited monthly to ensure all refunds dispersed to the proper agency, resident and/or representative in accordance with the federal regulations within 30 days. An interview was conducted on 10/16/24 at 2:32 PM, in conjunction with a record review with the Area Vice President and the Financial Counselor who stated the facility failed to forward the funds to the Clerk of Court and/or resident representative. The Financial Counselor stated the money should have been sent to the Clerk of Court within 30 days of death per policy. The Area Vice President stated the discrepancy was not discovered until an audit was done at the end of July 2024. The Area Vice President also stated the monies would be sent out immediately.	F 569		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		11/7/24

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F 580	Continued From page 4	F 580		

representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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F 580	Continued From page 5 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family, Nurse Practitioner, resident and staff interviews, the facility failed to notify the resident and the resident's Responsible Party of a medication change for 1 of 2 sampled residents (Resident #59). Findings included: Resident #59 was admitted to the facility on 2/4/21 with diagnoses that included stroke and atypical facial pain. The quarterly Minimum Data Set (MDS) dated 8/14/24 assessed Resident #59 with intact cognition. Review of Resident #59's profile revealed his family member was listed as his Responsible Party (RP). A nursing progress note dated 10/15/24 and recorded as a late entry on 10/16/24 by Nurse #1 revealed Resident #59 complained of increased pain to the left side of his face. Nurse Practitioner (NP) #3 was notified and prescribed 20 milligrams (mg) of Prednisone (steroid) one time followed by 5mg of Prednisone daily for a duration of three days. Also, the acetaminophen order was changed from 325mg every 12 hours to 650mg every 6 hours.	F 580	Corrective Action for the Resident Affected On 10/31/24, DHS and ADHS met with resident #59 to discuss plan of care and medication list. Responsible Party contacted via telephone to discuss updated medication list and plan of care. Action for Other Residents Potentially Affected On 10/31/24, the Director of Health Services performed an audit of all new orders over the last 7 days to ensure compliance. DHS identified any residents who needed notification of medication changes. As of 11/5/25, all residents and their RPs have been notified of medication changes. Systemic Changes As of 10/31/2024, the Director of Health Services and Clinical Competency Coordinator began education to licensed nurses, ensuring that all residents and their responsible parties are to be notified of any changes to their medications prior to administration. Education was completed on 11/6/2024. Newly hired licensed nurses will receive education and	

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F 580	Continued From page 6 A physician order with a start date of 3/13/24 and end date of 10/15/24 read, Acetaminophen 325mg - give 1 tablet by mouth twice daily for pain. A physician order with a start date of 10/15/24 read, Acetaminophen 325mg - give 2 tablets by mouth every 6 hours for pain. A physician order with a start and end date of 10/15/24 read, Prednisone 20mg - give 1 tablet by mouth once daily. A physician order with a start date of 10/15/24 and end date of 10/18/24 read, Prednisone 5mg - give 1 tablet by mouth once daily. During an interview on 10/16/24 at 1:04 PM, Nurse #1 revealed that Resident #59 was in a great deal of pain on 10/15/24, so she contacted NP #3 who then changed the Acetaminophen order and added Prednisone for 3 days. Resident #59 was not his own RP, and she was not able to contact the family because she was occupied with other residents and tasks. Resident #59 was interviewed on 10/15/24 at 9:17 AM. He revealed that his pain medication was changed at 5:00 AM in the morning. Resident #59 stated he was not told beforehand and did not know why it had changed. He indicated he had a great deal of facial pain on 10/15/24, but nothing was discussed about any medication changes. During a telephone interview on 10/16/24 at 12:38 PM, Resident #59's RP stated that he should be notified prior to all medication changes. The RP indicated that he was not told about the addition	F 580	training during Clinical Orientation The Director of Health Services will monitor all new orders during daily clinical meetings, to ensure licensed nurses maintain compliance. The Director of Health Services will monitor all new orders and notification of changes daily for 4 weeks, and monthly for 3 months. Monitoring The results of the notification of changes audit reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 11/7/2024	

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F 580	Continued From page 7 of Prednisone and the alteration to the Acetaminophen order prior to administration on 10/15/24. NP #3 was interviewed on 10/16/24 at 1:27 PM. She revealed that she was contacted by Nurse #1 on 10/15/24 regarding Resident #59's increased left-sided face pain. NP #3 indicated that Resident #59 was alert and oriented and his own RP. She stated she told Nurse #1 to discuss the changes with Resident #59 on 10/15/24. During an interview on 10/17/24 10:04 AM, the Director of Nursing (DON) revealed that the RP should be notified of any changes with medications. If a resident was considered cognitively intact, then any medication changes should be discussed with them, and nursing staff should inquire if they want their RP to be notified as well. The DON stated that Resident #59 should have been notified prior to the medication changes on 10/15/24 and asked if he wanted the RP to be notified as well. During an interview on 10/17/24 at 10:39 AM, the interim Administrator revealed that Nurse #1 should have notified Resident #59 and his RP of the medication changes that took place on 10/15/24.	F 580		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff	F 641	Corrective Action for the Resident	11/7/24

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F 641	Continued From page 8 interview the facility failed to accurately code the Minimum Data Set (MDS) assessments for Level II Preadmission Screening and Resident Review (PASRR) for 4 of 7 residents reviewed for MDS accuracy (Resident #43, Resident # 45, Resident #58, and Resident #61). Findings included: 1. Resident #43 was readmitted to the facility on 9/11/24. Review of a comprehensive MDS assessment dated 9/11/24 revealed Resident #43 had no cognitive impairment and was not coded for PASRR Level II or for Level II PASRR screening and conditions as required by the RAI manual (Resident Assessment Instrument). A letter dated 2/2/23 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services to the facility revealed Resident #43 had been determined to require a Level II PASRR. An interview with the Case Mix Director conducted on 10/17/24 at 11:59 AM revealed the MDS assessments were coded inaccurately, or the information was not available when coding as required by the RAI, and it was her expectation that all MDS assessments be coded as required by the RAI. An interview with the Administrator on 10/17/24 at 1:07 PM revealed that he expected all MDS assessments be coded correctly as directed by the RAI manual.	F 641	Affected As of 10/17/2024, the most current comprehensive Minimum Data Set (MDS) assessments for residents # 43, 45, 58, 61 were modified to correct coding to indicate a PASRR Level II, in section A. Action for the Residents Potentially Affected On 10/17/2024, the MDS Coordinator completed a 100% review of all current residents with a PASRR level II to ensure section A of the comprehensive MDS was coded correctly to reflect PASRR level II. If an MDS was noted to be out of compliance, that MDS was modified corrected on 10/17/2024 Systemic Changes On 11/05/2024, the MDS nurses received education related to the accuracy of assessments per the RAI guidelines by the Clinical Reimbursement Coordinator On 11/05/2024, the Administrator in-service the Social Worker, Activity Director on accuracy of assessment completion. Any newly hired staff will receive this training during the orientation process. The Director of Healthcare Services (DHS) or Administrator will review the accuracy of 3 Comprehensive assessments per week times 4 weeks, then 5 Comprehensive assessments per month for 3 months utilizing the QA	

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F 641	Continued From page 9 2. Resident #45 was readmitted to the facility 2/3/22. Review of a comprehensive MDS assessment dated 6/7/24 revealed Resident #45 had no cognitive impairment and was not coded for PASRR Level II or for Level II PASRR screening and conditions as required by the RAI manual (Resident Assessment Instrument). A letter dated 11/3/21 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services to the facility revealed Resident #45 had been determined to require a Level II PASRR. An interview with the Case Mix Director conducted on 10/17/24 at 11:59 AM revealed the MDS assessments were coded inaccurately, or the information was not available when coding as required by the RAI, and it was her expectation that all MDS assessments be coded as required by the RAI. An interview with the Administrator on 10/17/24 at 1:07 PM revealed that he expected all MDS assessments be coded correctly as directed by the RAI manual. 3. Resident #58 was readmitted to the facility 12/27/23. A review of a comprehensive MDS assessment dated12/30/23 revealed Resident #58 had no cognitive impairment and was not coded for PASRR Level II or for Level II conditions as required by the RAI manual.	F 641	Monitoring Tool for Accuracy of Assessments for PASRR level II, section A. Any inaccuracies noted will be corrected at the time of the review. Quality Assurance The results of the MDS accuracy reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 11/7/2024	

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F 641	Continued From page 10	F 641		

A letter dated 6/24/21 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services to the facility revealed Resident #58 had been determined to require a Level II PASRR.

An interview with the Case Mix Director conducted on 10/17/24 at 11:59 AM revealed the MDS assessments were coded inaccurately, or the information was not available when coding as required by the RAI, and it was her expectation that all MDS assessments be coded as required by the RAI.

An interview with the Administrator on 10/17/24 at 1:07 PM revealed that he expected all MDS assessments be coded correctly as directed by the RAI manual.

4. Resident #61 was admitted to the facility 4/4/24.

A review of a comprehensive MDS assessment dated 4/10/24 revealed Resident #61 had no cognitive impairment and was not coded for PASRR Level II or for Level II conditions as required by the RAI manual.

A letter dated 8/23/21 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services to the facility revealed Resident #61 had been determined to require a Level II PASRR.

An interview with the Case Mix Director conducted on 10/17/24 at 11:59 AM revealed the MDS assessments were coded inaccurately, or

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F 641	Continued From page 11 the information was not available when coding as required by the RAI, and it was her expectation that all MDS assessments be coded as required by the RAI. An interview with the Administrator on 10/17/24 at 1:07 PM revealed that he expected all MDS assessments be coded correctly as directed by the RAI manual.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		11/7/24

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F 656	Continued From page 12 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop an individualized, person-centered activities of daily living (ADL) care plan that included how much staff assistance was needed to care for a resident who required total assistance with ADL for 1 of 8 sampled residents reviewed for ADL (Resident #49). Findings included: Resident #49 was admitted to the facility on 06/21/23 with diagnoses that included spondylosis, muscle weakness, lymphedema, and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessment dated 7/16/24 revealed Resident #49 had intact cognition and required substantial to	F 656	Corrective Action for the Resident Affected On 10/17/2024, resident #49□s comprehensive care plan was updated in the area Activities of Daily Living (ADL) Action for the Residents Potentially Affected On 10/21/2024, the MDS nurse reviewed comprehensive care plans for all residents Activities of Daily Living (ADL). Of the 84 residents reviewed 72 were care planned, and 12 were not care-planned for ADL. On 11/4/2024, all residents identified with no comprehensive care plan for ADL, have been completed.	

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F 656	Continued From page 13 maximum assistance with toileting hygiene, personal hygiene, shower/bathing, upper/lower body dressing, putting on and taking off footwear, bed mobility, and transfers. Resident #49's comprehensive care plans, last revised on 7/23/24, did not include a plan that addressed her need for assistance with ADL. An interview with the MDS Coordinator #1 was conducted on 10/16/24 at 2:31 PM. She revealed that MDS updates the nursing care plan for all residents. It was important for ADL assistance to be included in all residents' care plans, so that nursing staff were provided with the appropriate care details. MDS Coordinator #1 thought she remembered adding the ADL assistance plan during Resident #49's admission but could not recall what happened to the focus. During an interview with the Director of Nursing (DON) on 10/17/24 at 10:02 AM, she revealed that every resident should have an ADL care plan focus because of the level of assistance the facility provided. The interim Administrator was interviewed on 10/17/24 at 10:40 AM. He revealed that a focus on ADL assistance should have been included in Resident 49's care plan.	F 656	Systemic Changes On 11/5/2024, the Clinical Reimbursement Consultant (CRC) in-serviced the MDS nurses, Activity Director, Social Worker, and Dietary manager on completion of a comprehensive care plan utilizing the company policy. Quality Assurance Director of Healthcare Services and/or Assistant Director of Healthcare Services (ADHS) will review 3 resident□s comprehensive care plans weekly x□s 4 weeks and then 2 residents comprehensive care plans assessments monthly x□s 3 months ensuring development and completion of the comprehensive care plan for ADL utilizing the QA Monitoring Tool for comprehensive care plans. Any missed Care plan will be corrected at the time of the review The results of these QA Monitoring Tool reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DHS and or ADHS for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained then quarterly thereafter. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of compliance: 11/7/2024	

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F 805	Continued From page 14	F 805		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with residents and staff, the facility failed to provide a resident with a cream gravy mix on her mechanical soft ground meats as specified on the meal ticket (Resident #68) and failed to provide food cut up into small pieces per the physicians order (Resident #22). This occurred for 2 of 2 sampled residents (Resident #68 and Resident #22). Findings included: 1. Resident #68 was admitted to the facility on 10/4/23 with diagnoses that included dysphagia. Review of the physician's orders for Resident #68 dated 10/5/23 read in part, "consistent carbohydrate (CCHO)/ liberalized diabetic diet, and mechanical soft consistency." A review of the Minimum Data Set (MDS) assessment dated 7/16/24 marked as a quarterly assessment, revealed resident was assessed as severely cognitively impaired and was coded as receiving mechanically altered and therapeutic diet. During a dining observation and resident interview on 10/14/24 from 11:45 AM to 1:05 PM,	F 805	Corrective Action for the residents found to be affected by the deficient practice: Resident #68 meal tray was corrected to include enough gravy immediately on 10/15/2024 and ongoing. Resident #22 tray ticket was corrected immediately to add the special instructions per the physician□s order. Corrective Action for other residents having the potential to be affected by the same deficient practice: On 10/17/24, an audit was completed of all current residents. This consists of comparing the physician prescribed diet orders with special notes to the meal tray card to ensure all special notes are included on the tray ticket. No other resident diet orders were identified with incorrect diet orders or incorrect special notes. Systemic Changes to ensure compliance: On 10/31/24 the dietary manager completed an In-service for all Dietary	11/7/24

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F 805	Continued From page 15 Resident # 68 was observed sitting in the dining room for her lunch meal. Observation of the resident's meal tray revealed the resident received an alternate meal option. The resident's meal tray consisted of chicken cut in cubes, rice and green peas. The resident was observed to have difficulty swallowing the food and Resident #68 was not eating her lunch. Resident #68 stated to the surveyor that the meat, and rice was too dry to eat. Review of the meal ticket indicated CCHO/liberalized diabetic - mechanical soft diet. The ticket indicated mechanical soft ground for meats and cream gravy mix. There was no gravy provided with her lunch meal. During an interview on 10/14/24 at 12:55 PM, the Nurse Aide (NA) #4 indicated she was unsure why the resident did not receive a soft moist tray. NA #4 stated it was the responsibility of the dietary staff to check the resident's meal tray for accuracy (diet and texture) before sending tray to the residents in the dining room. During a dining observation and resident interview on 10/15/24 from 12:05 PM to 12:30 PM, Resident #68 was observed sitting in the dining room for lunch. Resident was served her lunch tray. Observation of the lunch tray revealed the resident was served ground hamburger patty with a very small dollop of white gravy in the center. Review of the meal ticket had "alt" written on it, indicating alternate meal option. The resident indicated the hamburger was too dry and not to her liking as it was hard to eat. During an observation and interview on 10/15/24 at 12:30 PM, the Dietary Manager observed the resident's tray and acknowledged the meat was dry. The Dietary Manager stated the dietary staff	F 805	staff on the process of making sure that all mechanical soft meats are moist and sufficient gravy provided on the meal tray. This education will be provided to all new dietary staff on orientation. The dietary manager was educated on 10/31/2024 on ensuring all special instructions are correctly completed on residents meal tracker tickets The dietary manager or cook will Inspect 5 dietary trays with mechanical soft meats and accompanying gravy for enough gravy prior to tray line service. This audit will be done weekly for 4 weeks, then monthly for 3 months The Dietary manager will complete 5 new dietary orders for accuracy of transcription of the physician s order matching the meal tracker ticket. This audit will be done weekly for 4 weeks, then monthly for 3 months Monitoring Plan: The results of the dietary tray and Dietary meal tracker accuracy audit reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Dietary manager for review by the Interdisciplinary Team members monthly or until three months of compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: 11/7/2024	

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F 805	Continued From page 16	F 805		

had not poured adequate gravy on the ground hamburger patty to make it soft. She then went into the kitchen and brought some gravy to be poured over the hamburger to make it soft.

2. Resident #22 was admitted to the facility on 6/3/24 with dysphagia, sequelae of cerebral infarction (stroke) and contractures of left elbow.

Review of the physician orders dated 8/2/24 read in part "Regular diet, regular consistency. Special instructions: cut food into bite size pieces.

A review of the Minimum Data Set (MDS) assessment dated 8/9/24 revealed resident was assessed as cognitively intact. The assessment indicated resident needed set up/ clean up assistance for eating.

During a dining observation on 10/14/24 from 11:45 AM to 1:05 PM, Resident #22 was observed sitting in the dining room for lunch. Observation of the resident's meal tray revealed a chicken patty, rice and green peas. Review of the meal ticket revealed there were no instructions to cut food into bite size pieces. The resident was observed consuming her meals slowly and trying to cut the meat with her fork.

During a dining observation and resident interview on 10/15/24 from 12:05 PM to 12:30 PM, Resident #22 was observed sitting in the dining room for her lunch meal. Observation of the resident revealed the resident had only one tooth in her mouth. Observation of the resident's meal tray revealed a piece of baked chicken, mexican corn and vegetable blend. The meal ticket indicated no barbeque sauce and there were no instructions on the ticket to cut food into

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F 805	Continued From page 17 bite size pieces. Resident was observed trying to cut chicken with the fork and consuming small pieces of chicken. The resident indicated the baked chicken was very dry as it had no sauce or gravy on it and was having a hard time eating it. The resident indicated at times the staff cut her meat to bite size pieces. She indicated that she could not have the barbeque sauce. During an observation and interview on 10/15/24 at 12:30 PM, the Dietary Manager observed the resident's tray and she asked the resident if she would prefer some gravy and offered the resident some gravy. During an interview on 10/17/24 at 9:23 AM, the Dietary Manager stated the special instructions entered in the electronic health record (EHR) software do not always translate (transfer) to the dietary meal tracker software that printed the resident's meal tickets. She further stated that the special instructions were entered in the meal tracker software manually in the dietary meal tracker software. The Dietary Manager indicated that it was a human error, and the special instructions were not entered and did not reflect on the meal ticket. During an interview on 10/17/24 at 9:48 AM, the Director of Nursing (DON) indicated the meal tickets should match the physician orders, so that the residents received the diet ordered. She indicated the consistency of food should be checked by the dietary staff prior to being sent out to the dining table. DON stated the dietary staff, and the nursing staff should check the tray for accuracy before serving trays to the residents.	F 805		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		11/7/24

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F 812	Continued From page 18 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 observations and interviews, the facility failed to maintain the dry goods storage area clean and failed to label and date food in one of one walk-in refrigerator. The facility also failed to ensure dietary staff facial hair coverings during food preparation in the kitchen. These practices had the potential to affect food served to residents. Findings included: 1. During an observation of the dry goods storage area on 10/14/24 at 9:15 AM, there was big white container with wheels. The white container had no lid. The was an opened paper bag inside the box. There was large amount white powdery	F 812	Corrective Action for the residents found to be affected by the deficient practice: The dry goods storage area had sugar spilled on the floor and around the side of the storage container. It was cleaned up immediately on 10/14/2024. The reach-in refrigerator had 3 opened 46-ounce cartons of nectar thickened tea not dated, 1 opened 46-ounce carton of honey thickened tea not dated, and one clear 4-quart food storage container with no label or date on it. All items were discarded immediately on 10/14/2024. A dietary aide had no beard guard on while working in the kitchen. The dietary aid put	

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F 812	Continued From page 19 substance on the floor, around and on the side of the white container. During an interview on 10/14/24 at 9:17 AM, the Dietary Manager indicated the white container contained sugar and added staff had accidentally dropped sugar on the floor during breakfast preparations. The Dietary Manager indicated the area should be cleaned immediately by the staff when any spills were made. 2. During an observation of the reach-in refrigerator on 10/14/24 at 9:20 AM, revealed there were three opened 46-ounce cartons of nectar thick tea that were not dated, one opened 46-ounce carton of honey thick tea that was not dated and one clear plastic four-quart container one fourth filled with diced fruit with no label or date on them. Review of the manufacture recommendations for thickened liquids, revealed the beverage should be refrigerated after opening and should be discarded within 72 hours. During an interview on 10/14/24 at 9:23 AM, the Dietary Manager stated the thickened liquids were used during mealtime for residents with physician orders. The diced fruit was fruit cocktail that was used during the previous meal. She indicated opened cartons of thickened liquids should be labeled with an opened date and stored in the refrigerator for 3 day. The Dietary Manager stated all left over food should be labeled with a used by date prior to be placed in the refrigerator. 3. During an observation on 10/14/24 at 9:25 AM, Dietary Aide #1 was observed working near the food preparation station. The Dietary Aide was	F 812	a beard guard on immediately. Corrective Action for other residents having the potential to be affected by the same deficient practice: All Dietary Staff was in-serviced on 10-31-24 on cleaning up spills immediately after they occur, food storage, dating and labeling, and the use of facial hair coverings and beard guards. Systemic Changes to ensure compliance: All Dietary Staff were in-service on 10-31-24 on cleaning up spills immediately after they occur, food storage, dating and labeling, and the use of facial hair coverings and beard guards. This education will be provided to all new dietary staff on orientation The dietary manager to complete a kitchen observation for weekly for 4 weeks and then monthly for 3 months to ensure sanitation, proper food storage labeling and dating, and the use of beard guards are in effect. All deficient practice will be addressed immediately Monitoring Plan: The results of the kitchen observation audit reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Dietary manager for review by the Interdisciplinary Team members monthly or until three months of compliance is	

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F 812	Continued From page 20 assisting in food preparation for the lunch meal. The staff had facial hair (beard) that was not covered with a beard covering / guard while working in the kitchen. During an interview on 10/14/ 24 at 9:30 AM, the Dietary Aide #1 stated he had just started his shift and forgot to wear a beard covering. He indicated there were beard coverings available in the dietary manager's office. During an interview on 10/14/24 at 9:32 AM, the Dietary Manager stated there were boxes of beard covering available to dietary staff to use as needed. She indicated the staff had just started his shift and must have forgotten to wear one. During an interview on 10/17/24 at 1:00 PM, the Director of Nursing (DON), indicated all male staff when in kitchen should be wearing a beard covering if they have facial hair. The DON stated all thickened liquids should be dated when opened, placed in the refrigerator and discarded within 72 hours. The DON stated that hairnets and beard guards should be worn by staff while in the kitchen.	F 812	sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. Date of Compliance: 11/7/2024	