| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced Recertification and complaint survey was conducted on 06/21/21. The facility was found to be in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID #8HH511. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced on cite recertification and complaint survey was conducted on 06/21/21. Immediate Jeopardy was identified as:<br><br>CFR 483.12 at tag F600 at scope and severity of (J). An extended survey was conducted F600 constituted substandard quality of care The immediate jeopardy began on 01/30/21 and was removed on 06/10/21.<br><br>One of two of the complaint investigations were substantiated and resulted in the deficiency (F600 J). | F 000 | | |
| F 600 SS=J | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or | F 600 | | 6/21/21 |

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

Electronically Signed | 07/08/2021

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| F 600 | Continued From page 1<br>involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, physician interview and record review the facility neglected to identify the urgency for the need for medical treatment for a resident taking Plavix 75 MG (Milligrams) daily and Aspirin 81 MG daily, both antiplatelet medications that prevent the blood from clotting causing increased bleeding, after a fall with a head injury to his forehead and nose and after a second fall with an injury to the back of his head for 1 of 7 residents reviewed for accidents (Resident #240). Resident #240 was sent to the hospital for evaluation at approximately 8:20 AM on 01/30/21 by the on-coming shift. He expired the next day (01/31/21) at the hospital with discharge diagnoses of subdural hematoma and death.<br><br>Immediate Jeopardy began on 01/30/21 when Resident #240 experienced falls with a head injury at 2:45 AM and again at 6:00 AM and the facility neglected to initiate immediate medical attention. 911 was not called until 7:54 AM. Immediate Jeopardy was removed on 06/10/21 when the facility provided and implemented an acceptable plan of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective.<br><br>Findings included:<br><br>Resident #240 was admitted to the facility on 12/11/20 with diagnoses that included Cerebral infarction (stroke), syncope and collapse, | F 600 | Davis Health Care Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Davis Health Care Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Davis Health Care Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings.<br><br>1. Resident #240 is no longer in the facility. Resident admitted to Davis Health Center 12/11/20 with primary diagnosis of Acute Respiratory Failure, Type 2 Diabetes Mellitus, Cerebral Infarct, Chronic Congestive Heart Failure (in part). Resident chart documentation reflects at approximately 2:45 a.m. on 1/30/21, resident observed sitting on floor at foot of bed. Nurse assessment reveals hematoma to forehead with small straight line laceration to nose. Nurse and resident clean resident face, resident assisted back to bed. Nurse initiates neuro checks, | |

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| F 600 | Continued From page 2<br>unsteadiness on feet, muscle weakness and altered mental status.<br><br>Review of an admission Minimum Data Set (MDS) assessment dated 12/17/20 revealed Resident #240 had mildly impaired cognition. He had trouble sleeping and concentrating on 12-14 days during the assessment period with hallucinations. He required limited assistance with bed mobility, dressing and personal hygiene. He was not steady and was only able to stabilize with staff assistance for moving from a seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfers. He had no impairment of his upper or lower extremities. No mobility device was selected. At the time of the assessment, he had falls prior to admission and one fall since admission with no injury. He received Physical Therapy on 5 days during the assessment look back period.<br><br>The following care plan was dated 01/29/21. Falls: Resident #240 was at risk for falls related to diagnoses of acute respiratory failure with hypoxia, Diabetes Mellitus Type 2, Cerebral Vascular Accident, congestive heart failure, syncope/collapse, unsteadiness on feet, muscle weakness and acute mental status change. The goal target date was 05/01/21 for Resident #240 not to sustain serious injury related to falls through the next review. Approach start date of 01/29/21: Assess fall risk upon admission, quarterly and as needed; encourage resident to call for assistance prior to transferring or ambulating; keep call bell within reach and answer promptly; keep frequently used items within reach; keep pathways free from clutter and provide adequate lighting; non-skid footwear | F 600 | (rule of 4's) retrieves Vital Signs (132/79-97.9-69- 17. 99% RA). Nurse documents per chart, called and left message with responsible party following first event. The nurse did not notify the physician that the resident fell and hit his head, as nurse documents resident remained at baseline for Range of Motion, cognition and denying pain. Nurse stated reviewed medications at time of fall, however, did not see blood thinning agent. Later in same shift resident observed sitting on floor side of bed with shoes on. Nurse documented assessment reveals 2.5 x 0.5 abrasion to back of head with small amount of blood. Resident unable to recall event. Vital Signs retrieved (144/69-97.9-86-20-98% RA). Neuro checks continue to be normal. At change of shift, day shift nurse enters room observes resident sitting on bed. Nurse denotes hematoma to both forehead and back of head. Resident voices headache, back pain and dizziness. Nurse immediately calls on-call provider and notifies supervisor. Both nurses assessing resident, stating condition deteriorating rapidly. EMS is activated and resident is sent via stretcher to hospital. Wife is notified of falls and transfer to hospital. Later in day Clinical Coordinator has follow-up conversation with family. Hospital reports CT reveals subdural hematoma, resident unresponsive, code status changed to DNR with palliative consult. Per hospital record, resident was admitted on 1/30/21 and expired on 1/31/21 with discharge diagnosis of subdural hematoma, death. | |

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| F 600 | Continued From page 3<br>when out of bed; Physical Therapy for balance, gait, transfers and safety as indicated; resident to be in common area for frequent observation when possible.<br><br>A nursing note written on 01/30/21 at 3:45 AM by Nurse #1 documented, "CNA reported to this writer that resident was sitting on the floor in his bedroom. This writer observed resident sitting on the floor at the foot of his bed legs crossed in front of him holding his head with both hands. Resident unable to recall how he got on the floor. States he hit his head this writer noticed a hematoma to resident forehead and blood from a straight line laceration across his nose. Resident assessed for further injury. No other injury noted at this time. Assisted resident to bed with some resistance by resident. Asked resident if he felt he needed to go to the hospital and resident declined and said he would be ok. Resident was pleasant but did not appear to want much help from staff. Gave resident wash cloth to wipe blood off his nose. Attempted to assist resident declined. Stated he is ok and wanted to rest in bed. Neuro checks initiated and WNL (within normal limits). VSS (vital signs stable) 132/79-97.9-69-17-99% (blood pressure, temperature, heart rate, respirations, oxygen saturation) on room air. Called RP (Responsible Party) and left voicemail message."<br><br>Facility Neurological Check Sheets generated for Resident #240 were reviewed. The first set of neurological check sheets began at 2:45 AM on 01/30/21 after the first fall with no abnormal findings documented. The second set of neurological check sheets began on 01/30/21 after the second fall with no abnormal findings documented. Assessments were documented as | F 600 | 2. Other residents have been identified as ordered and receiving blood thinners. Residents with a fall and receiving blood thinners in the past 60 days from 6/9/2021 have been reviewed and care plans revised as appropriate.<br><br>3. Facility nurse education was initiated on 6/9/21 and completed on 6/21/21 on the revised protocol for intervention for residents experiencing a fall and on blood thinner and the Falls Risk Assessment and Prevention Policy. Education was provided by the Clinical Coordinator Nurses and RN Staff Educator in person and with written materials and via telephone with employees who were not scheduled to work.<br><br>Facility nursing assistant education was initiated 6/10/21 and completed on 6/21/21 on the Falls Risk Assessment, prevention and intervention policy and the nursing assistant protocol for identifying residents on a blood thinner. Education was provided by Clinical Coordinator Nurses/RN Staff Educator in-person with written materials and via telephone with employees who were not scheduled to work.<br><br>4. The DON or designee will review falls of residents receiving blood thinners weekly for 3 months. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months. | |

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| F 600 | Continued From page 4 | F 600 | | |

completed every 15 minutes x 4, then every 30 minutes x 4 after the first fall and every 15 minutes x 4 after the second fall before the resident was transferred to the emergency room. The last neurological check was completed at 7:15 AM.

A second nursing note written on 01/30/21 at 7:29 AM by Nurse #1 documented, "CNA reported to this writer that resident was sitting on the floor at bedside and has small amount of blood on the back of his head. This writer observed resident sitting beside his bed feet in front and legs crossed with his shoes on. Resident has a 2.5 x 0.5 abrasion to the back of his head. Resident unable to recall events that led him to be on the floor. Assessed for further injury with none noted at this time. VSS 144/69-97.9-86-20-98% RA (room air). Neuro checks WNL."

During a telephone interview with Nurse Aide #1 on 06/09/21 at 10:45 AM she stated at approximately 2:30 AM on 1/30/21 she did rounds and found Resident #240 sitting on the floor and at approximately 6:00 AM she went back and again and he was sitting on the floor. She reported both incidents to the nurse immediately. She remembered she noticed a hematoma on his forehead after the first fall and a bruise on the back of his head after the second fall. She recalled the resident was confused but alert. She remembered the nurse asked him if he wanted to go to the hospital after the first fall and he declined. He told her he was "ok" when she asked him.

During a telephone interview with Nurse #1 on 06/08/21 at 6:57 PM she stated she remembered Resident #240. She recalled he was usually quiet

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and sat with his head down. She recalled the first fall occurred around 3:00 AM. She stated he had responded appropriately to questions and did not want to be bothered. She felt he was capable of making the decision not to go to the hospital and that it was normal for him to resist care. She stated she started neuro checks after the first fall. She could not remember how often she completed the neuro checks. She did not remember calling the physician. She stated she did not know the resident was on a "blood thinning" medication. She noted that because his vital signs were normal and he had stated he did not want to go out she had not sent him to the emergency room. She stated she had called the family and left a voice message. She could not recall what time the second fall had occurred but remembered it was toward the end of her shift in the morning. She stated if she had known Resident #240 was on a "blood thinner" she would have called the physician after the first fall for instructions. She could not remember how often the resident was checked during the night between the first and second fall. She believed she saw Resident #240 right before she left her shift in the morning and he may have been lying in bed but stated she didn't really remember.

During a second telephone interview with Nurse #1 on 06/19/21 at 4:20 PM she stated she could not remember how many times she assessed Resident #240. She recalled when she had completed the neurological assessments she used a "little flash light pen thingy" to assess his pupils, and checked his movement by having the resident squeeze her hands. She could not recall which questions she had asked him to determine his level of alertness. She did recall he was awake most of the night with his light on but could

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not remember if he had a roommate. She stated after Resident #240 fell at approximately 6:00 AM she was also completing other tasks that included passing medications to other residents, giving report to the oncoming shift and completing the narcotic count. She could not remember how many times staff checked on the resident after the second fall. She stated she had not called the physician or sought emergency medical attention for the resident.

A nursing note written on 01/30/21 at 8:00 AM by Nurse #3 documented, "Resident observed sitting on edge of bed with large hematoma on his forehead and a large hematoma on the back of his head. Resident complains of headache, dizziness and back pain. Phoned on call provider, no answer. Notified Supervisor (Nurse #2) and called 911. EMS arrived and took resident out of facility via stretcher. Notified (family member) of injury and transfer to hospital."

During a telephone interview with Nurse #3 on 06/08/21 at 7:52 PM she stated she had came on shift the morning of 01/30/21 and in report from Nurse #1 she learned Resident #240 had fallen twice during the night so she went to check on him as soon as she got out of report. She commented he was sitting on the edge of his bed trying to put his pants on. He was holding his head, so she asked him if his head hurt. He replied his head hurt and he was dizzy. She recalled he was determined he was getting up so she helped him put his pants on and got him up to a wheelchair. Nurse #1 was leaving and she asked her if she had called the provider. She remembered Nurse #1 told her she had sent the provider an email. The supervisor, Nurse #2,

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came through at that time and she asked her to assess the resident. They both decided he needed to go to the emergency room. She stated she called the provider and did not get an answer so they sent the resident out, sometime between 7:30 and 8:00 AM. She recalled the physician called back later and she told her she had sent the resident to the emergency room. She commented she knew immediately that he needed to go to the emergency room because he had a headache and was dizzy after falling twice. She indicated she would have called the provider after the first fall and obtained orders because Resident #240 was on a blood thinner and had a hematoma on his head.

During an interview with Nurse #2, Clinical Coordinator and Weekend Supervisor, at 12:40 PM on 6/7/21 she stated she was familiar with Resident #240. She had gone to make rounds the morning of 1/30/21. She discovered Resident #240 had fallen in the early morning and then again toward the end of third shift. She recalled he was up in a wheelchair when she arrived. The day nurse asked her to look at him because she didn't think he looked right. She assessed the resident and agreed. She remembered he was not talking like he normally did and his pupils were not equal. She stated she told Nurse #3 to send him out for evaluation. She noted he declined rapidly and in a few seconds time he was not responding and hung his head down. She commented she looked at the neuro checks that had been completed during the night and they looked normal. She explained he had been on a fall protocol that included an optimal low bed (when sitting on edge feet touched the ground), frequent checks, call bell within reach, when ambulating used his walker, and reminders not to

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get up alone. She stated he had intermittent confusion. She said staff had met after the falls and talked about what staff could have done differently to prevent the falls and decided staff had done everything to prevent him from falling. She learned after the first fall he went back to sleep then woke up and fell again. She said staff later went into his room to try to determine where he had fallen and look for evidence of blood where he might have hit his head on but couldn't find any clues. She reiterated when she initially encountered him he was talking to staff and then he hung his head and stopped talking.

Review of the EMS (Emergency Medical System) records documented a 911 call was received at 7:54 AM on 01/30/21. EMS arrived at the facility at 8:00 AM. At 8:07 AM EMS recorded the following vital signs for Resident #240: Blood pressure 210/86, heart rate 76, respirations 20, oxygen saturation 88%, pain level 10. EMS documented he had a hematoma to the forehead, dried blood on the bridge of his nose and a fresh abrasion and hematoma to the back of his head. He was on a "blood thinner." Resident #240 complained of head and neck pain and was placed in a cervical collar. He was transported to the emergency room and arrived at the hospital at 8:45 AM.

Review of the hospital record dated 01/30/21 documented the patient (Resident #240) was evaluated in the Emergency Department after a fall and documented: He had apparently fell and hit the back of his head and there was also a contusion on the anterior (front) side. The patient was on Plavix. A scan was performed and revealed an acute right cerebral (brain) convexity hematoma measuring up to 3.2 CM

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(Centimeters) in thickness over the frontal lobe (of the brain). There was a 9 MM (Millimeter) leftward midline shift. There was also a posterior (back of the head) scalp hematoma. He was evaluated by Neurosurgery and found to not be an operative candidate, thus making his injury not survivable. He expired on 01/31/21 at 7:06 PM. The hospital documented his discharge diagnoses as subdural hematoma and death.

During an interview with the on-call physician on 06/08/21 at 4:15 PM she stated she was familiar with the incident and confirmed she had been the physician on-call that weekend. She said staff first called her around 8:00 AM on 1/30/21 after they had sent the resident out to the emergency room. She stated she had not been called in the middle of the night when Resident #240 first fell. She explained she would have expected staff to call her the first time he fell. She noted she would have sent him out at that time knowing he had hit his head and that he was on a "blood thinner" (Plavix). She commented that not all residents who fell and hit their head were sent out if they had not had any symptoms but because he was on Plavix she would have ordered him to be sent for evaluation. She further explained she knew the resident fell twice but said she could not determine which fall was fatal. She stated Resident #240 would have been able to tell staff if he had a headache, which was the first sign of a subdural hematoma, but also knew the resident had some confusion and was not sure if he was able to determine on that night if he needed to go to the hospital or not. She stated she would have sent him out had she been called.

The Executive Administrator and the Clinical Services Administrator were notified of Immediate

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Jeopardy on 06/09/21 at 5:52 PM.

Immediate Jeopardy Removal Plan
Davis Health Care Center
June 10, 2021

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

a. Resident #240 is no longer in the facility. Resident admitted to Davis Health Center 12/11/20 with primary diagnosis of Acute Respiratory Failure, Type 2 Diabetes Mellitus, Cerebral Infarct, Chronic Congestive Heart Failure (in part). Resident chart documentation reflects at approximately 2:45 a.m. on 1/30/21, resident observed sitting on floor at foot of bed. Nurse assessment reveals hematoma to forehead with small straight line laceration to nose. Nurse and resident clean resident face, resident assisted back to bed. Nurse initiates neuro checks, (rule of 4's) retrieves Vital Signs (132/79-97.9-69- 17. 99% RA). Nurse documents per chart, called and left message with responsible party following first event. The nurse did not notify the physician that the resident fell and hit his head, as nurse documents resident remained at baseline for Range of Motion, cognition and denying pain. Nurse stated reviewed medications at time of fall, however, did not see blood thinning agent. Later in same shift resident observed sitting on floor side of bed with shoes on. Nurse documented assessment reveals 2.5 x 0.5 abrasion to back of head with small amount of blood. Resident unable to recall event. Vital Signs retrieved (144/69-97.9-86-20-98% RA). Neuro checks continue to be normal. At change of shift, day

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|---|---|---|---|
| | 345160 | A. BUILDING _____ B. WING _____ | C 06/21/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DAVIS HEALTH CARE CENTER | 1011 PORTERS NECK ROAD WILMINGTON, NC 28411 |

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| F 600 | Continued From page 11 | F 600 | | |

shift nurse enters room observes resident sitting on bed. Nurse denotes hematoma to both forehead and back of head. Resident voices headache, back pain and dizziness. Nurse immediately calls on-call provider and notifies supervisor. Both nurses assessing resident, stating condition deteriorating rapidly. EMS is activated and resident is sent via stretcher to hospital. Wife is notified of falls and transfer to hospital. Later in day Clinical Coordinator has follow-up conversation with family. Hospital reports CT reveals subdural hematoma, resident unresponsive, code status changed to DNR with palliative consult. Per hospital record, resident was admitted on 1/30/21 and expired on 1/31/21 with discharge diagnosis of subdural hematoma, death.

b. 39 residents have been identified as ordered and receiving blood thinners. 4 of the 39 residents identified as receiving blood thinners have had a fall in the past 60 days.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

a. The facility policy regarding intervention for residents experiencing a fall and on blood thinner was revised 6/9/21. The Physician will be contacted for instruction on how to care for residents who have fallen and are on blood thinner even in the absence of apparent injury.

b. Care plans for the identified residents were reviewed 6/9/21 by Clinical Coordinator Nurses and DON to ensure blood thinner is noted on the care plan.

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| F 600 | Continued From page 12 | F 600 | | |

c. Training:

i. Facility nurse education initiated on 6/9/21 on the revised protocol for intervention for residents experiencing a fall and on blood thinner. Education was provided by Clinical Coordinator Nurses and RN Staff Educator in person and with written materials. 11 Nurses received the education on 6/9/21. Education continues for other nurses by Clinical Coordinator nurses/RN Staff Educator or designee prior to the start of their next worked shift. Any staff from Agencies will receive the same education prior to any worked shift by the Clinical Coordinator/ RN Staff Educator or designee. The training is recorded on a training log with staff signature.

ii. Facility nursing staff education initiated 6/9/21 on the Falls Risk Assessment and Prevention Policy. Education was provided by Clinical Coordinator Nurses/RN Staff Educator in-person with written materials. 11 Nurses received the education on 6/9/2021. Education continues for other staff by Clinical Coordinator nurses/RN Staff Educator or designee prior to the start of their next worked shift. Any staff from agencies will receive the same education prior to any worked shift by the Clinical Coordinator nurses/RN Staff Educator or designee. The training is recorded on a training log with staff signature.

d. All nurses, both staff and agencies, will receive training regarding immediate medication review for all fall events to see if blood thinning agent is being used. This training is being provided by Clinical Coordinator nurses/RN Staff Educator or designee and will begin promptly.

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| F 600 | Continued From page 13<br><br>Person Responsible for implementing the Removal Plan: Clinical Coordinator Nurses/RN Staff Educator or designee.<br><br>Facility alleges Immediate jeopardy was removed 6/10/2021.<br><br>The Removal Plan of Immediate Jeopardy was validated on 06/10/21 at 5:15 PM.<br><br>A sample of staff that included nurses, nurse aides, medication aides and a case manager were interviewed regarding in-servicing related to the deficient practice. Three staff members were in the process of being in-serviced during the validation process and all other nursing staff interviewed stated they had been in-serviced regarding the facility policy and procedure related to Fall Risk Assessment and Prevention and Post Fall Protocol including in-person education and written materials. Training included all nurses, both staff and agencies. A review of all documents developed to correct the deficient practice was completed. All facility policies and procedures that were revised to address the deficient practice were reviewed. A review of audit forms that were developed to ensure that in-services presented to all staff were understood and allowed an opportunity for staff to interact with dialogue were also reviewed. Immediate Jeopardy was removed on 06/10/21 at 5:40 PM. | F 600 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must - | F 812 | | 6/21/21 |

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| F 812 | Continued From page 14<br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews the facility failed to ensure frozen items were sealed. Foods in kitchen freezer were in plastic bags opened to air, one large bag of chicken breasts and one large bag of hamburger patties. This practice had the potential to affect food quality. Additionally, facility failed to allow 2 of 12 six-inch stainless-steel hotel pans and 20 sampled (10 glass and 10 plastic) 10 ounce drinking glasses to dry prior to stacking or placing in cupboard.<br><br>The findings include:<br><br>1. An observation on 06/07/21 at 12:15 PM of the kitchen's reach in freezer, with the Assistant Dietary Manager (ADM #1) revealed; a clear plastic bag of hamburger patties, and a clear plastic bag of chicken breasts not sealed and were open to air. The ADM was unable to explain why food stored in the kitchen's reach-in freezer were open to air. | F 812 | 1. The identified pans and glasses were removed for proper drying during on site survey. The identified frozen items were properly sealed during the onsite survey.<br><br>2. Other pans and glasses were audited to ensure proper drying. Other frozen items were audited to ensure proper sealing.<br><br>3. All Dining Staff was retrained regarding proper drying of pans and glasses and proper sealing of frozen items beginning on 6/9/2021 and completed on 6/14/2021. Education was provided by the Dining Director/Supervisor in-person with written materials and via telephone with employees who were not scheduled to work.<br><br>4. The Dining Director or designee will | |

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| F 812 | Continued From page 15<br><br>During an interview with the ADM on 06/07/21 at 12:18 PM he said he and the Dietary Manager (DM) monitored the items in the refrigerators and freezers weekly when conducting inventory. He stated the hamburger patties and chicken breasts should have been sealed and not opened to air.<br><br>2. An observation with the ADM #1 was made on 06/07/21 at 12:25 PM of food preparation pans that were stored on the kitchen shelf and were ready for use. When separated, two of the stored six-inch stainless steel food preparation pans were observed to have moisture on them and were stacked together and had moisture in between the two stacked pans.<br><br>During an interview with the ADM on 06/07/21 at 12:28 PM he stated the pans should be air dried prior to stacking.<br><br>During an interview with the Administrator on 06/10/21 at 1:05 PM, he reported it was his expectation the facility's kitchen staff follow all regulatory guidelines for food and kitchen sanitation safety. | F 812 | audit to ensure frozen items are sealed and proper drying of pans and glasses weekly for 3 months. The findings will be reported to the QAPI committee for review of performance improvement monthly for 3 months. | |