STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING _____ B. WING _____	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(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 survey was conducted on 10/3/2021 through 10/6/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # V1TI11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 10/3/2021 to 10/6/2021. Event ID # V1TI11.	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when	F 563		10/25/21

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

Electronically Signed | 10/28/2021

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F 563	Continued From page 1 such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on family and staff interviews, the facility imposed a restricted visitation schedule which limited resident visitations for 1 of 2 residents reviewed for visitation. (Resident #34). The findings included: Resident #34 was admitted to the facility on 7/15/20 with diagnoses of hypertension and diabetes. The quarterly minimum data set dated 9/23/21 revealed Resident #34 was cognitively intact. On 10/5/21 at 4:20 PM, an interview was conducted with the Social Worker. She stated resident visitation was scheduled by appointment and asked that appointments be made 24 hours in advance. She also stated visits are preferred between 10:00 AM and 3:00 PM but visits have occurred after that time. On 10/5/21 at 4:45 PM, the Activities Director was interviewed. She stated the Social Worker and the business office worked together to set up the appointments for visitation. She stated scheduled appointments were between 10:00 AM and 4:00 PM for indoor and outdoor visits. Resident #34 was interviewed on 10/6/21 at 10:05 AM. She stated her daughter had to make an appointment for visitation.	F 563	"On 10/20/2021, Administrator reviewed and revised, if applicable, facility policy Indoor and Outdoor Visitation. "On 10/20/2021, Administrator initiated an in-service to all facility staff to be conducted by Director of Nursing/Designee on facility visitation policy focusing on the resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the residents right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. Any facility staff not in-serviced by 10/25/2021 will be prior to next scheduled shift. "On 10/21/2021, Business Office Manager mailed an informative letter of visitation to all resident responsible parties to ensure the resident has the right to receive visitors of his or her choosing at the time of his or her choosing subject to the residents right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. "For continued monitoring, random selection of 25% of responsible parties will be interviewed via phone by Admissions/Social Worker/Designee to ensure knowledge of facility visitation	

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F 563	Continued From page 2 An interview was conducted with the Director of Nursing on 10/6/21 at 4:45 PM. She stated we ask visitors to make an appointment, but if they come to the facility, we don't tell them they can't come in. On 10/6/21 at 5:32 PM, an interview was conducted with Resident #34's daughter. She stated she visits her mother about once a week and had to make an appointment to come see her. She stated she was unaware the facility was open to visitation without having to make an appointment.	F 563	policy. Audit to continue weekly times 4 weeks to total 100%. "All newly admitted residents will receive informative letter of visitation included in Admission packet to ensure any new resident has the right to receive visitors of his or her choosing at the time of his or her choosing, subject to the residents right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. "All newly employed staff will be educated during the orientation process on facility policy Indoor and Outdoor visitation focusing on the resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the residents right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. "Results of responsible party interviews will be presented by Admissions/Social Worker/Designee at the next scheduled Quality Assurance Committee meeting for review and again at the following quarterly Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	
F 641 SS=D	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	F 641		10/25/21

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F 641	Continued From page 3 by: Based on observation, staff interviews, and record review the facility failed to accurately code the Minimum Data Set (MDS) for weight loss, anticoagulants, and indwelling catheter for 3 of 13 (Resident # 2, #11, & #28) MDS assessments reviewed. The findings included: 1. Resident #2 was admitted to the facility on 6/30/18. Her diagnoses included Diabetes, chronic obstructive pulmonary disease, abnormal weight loss and anxiety disorder. The current care plan for Resident #2 with a revision date of 7/22/19 revealed she was at "risk for less than body requirement related to being on a therapeutic diet" due to diagnosis of diabetes. A progress note written by the Registered Dietitian dated 5/26/21 revealed Resident #2 had a significant weight loss identified as 11.8 % loss in the last 6 months. The quarterly MDS dated 7/1/21 indicated Resident #2 was cognitively intact. She was independent for locomotion and eating. She required limited assistance for dressing. She weighed 93 pounds, had no weight loss and received a therapeutic diet. On 10/5/21 at 12:59 PM the Registered Dietitian stated she had identified a significant weight loss for Resident #2 during her May 2021 visit and wrote the note dated 5/26/21. During an interview with the Dietary Manager on 10/6/21 at 10:20 AM she stated she was	F 641	"On 10/06/2021, modification of quarterly/annual MDS assessments for residents 2, 11, and 28 were completed. "On 10/20/2021, Administrator initiated an in-service to be conducted by Administrator/Designee for all staff responsible for completing sections on the MDS on F641 focusing on qualified health professionals correctly document the resident□s medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument specific to correct documentation of weight loss, anticoagulants, and indwelling catheters. Any facility staff not in-serviced by 10/21/2021 will be prior to next scheduled shift. "On 10/21/2021, Administrator initiated an audit to be conducted by MDS Coordinator/Designee on all in-house resident MDS assessments to ensure correct documentation of weight loss, anticoagulants, and indwelling catheters. Audit to be completed by 10/22/2021. "For continued monitoring, random selection of 25% of in-house resident MDS assessments are to be audited by Administrator/Designee to ensure correct documentation of weight loss, anticoagulants, and indwelling catheters. Modification assessments will be submitted for any assessment found to	

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F 641	Continued From page 4 responsible for the coding of Section K of the MDS. She stated she was not aware Resident #2 had a significant weight loss. She stated the MDS was not coded correctly since Resident #2 had a significant weight loss. 2. Resident #11 was admitted to the facility on 1/20/13. Her diagnoses included congestive heart failure, diabetes, hyperkalemia (high potassium blood level) and atrial fibrillation. She was receiving hemodialysis. The physician order dated 6/27/21 revealed Resident #11 was to receive Plavix 75mg every (q) morning for peripheral vascular disease (PVD). The quarterly MDS dated 7/28/21 indicated Resident #11 was cognitively intact. She received an anticoagulant for 7 day of the look back period. On 10/6/21 at 8:45 AM MDS nurse #1 stated she completed the MDS dated 7/28/21. She reviewed the electronic medical record for Resident #2 and stated she was receiving Plavix which was an anticoagulant. She then reviewed the Resident Assessment Instrument (RAI) which revealed Plavix was an antiplatelet and should not be coded as an anticoagulant. She said coding Plavix as an anticoagulant was an error. 3. Resident #28 was admitted on 1/27/2016, and diagnoses included neurogenic bladder. Resident #28's care plan dated 11/6/2019 included an altered patten of urinary elimination with an urostomy, and interventions included care of an urostomy. The annual Minimum Data Set (MDS)	F 641	not have correct documentation of weight loss, anticoagulants, and indwelling catheters. Audit to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed staff responsible for completion of MDS assessments will be educated during the orientation process on F641 focusing on correctly documenting the resident□s medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument specific to weight loss, anticoagulants, and indwelling catheters. "Results of all in-house resident MDS audits will be presented by Administrator/Designee at the next scheduled Quality Assurance Committee meeting for review and again at the following quarterly Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	

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F 641	Continued From page 5 assessment dated 8/29/2021 revealed Resident #28 had an indwelling catheter and ostomy for elimination. On 10/6/2021 at 6:40 a.m. in an interview with Nurse #2 she stated Resident #28 did not have an indwelling catheter. She stated Resident #28 had an urostomy and a colostomy for elimination of urine and stool. On 10/6/2021 at 7:01 a.m. an urostomy bag and a colostomy bag were observed on the left side of Resident #28's abdomen. On 10/6/2021 at 10:10 a.m. in an interview with the MDS Nurse #1, she stated Resident #28 had an urostomy and a colostomy for elimination, and indwelling catheter should not had been coded on the MDS. On 10/6/2021 at 10:15 a.m. in an interview with the Director of Nursing, she stated Resident #28 did not have an indwelling catheter, and the MDS was coded incorrectly. She stated Resident #28 had two different ostomies for elimination of urine and stool.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		10/25/21

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F 657	Continued From page 6 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and revise the care plan after the last quarterly assessment for significant weight loss for 1 (Resident #2) of 2 residents reviewed for nutrition. The findings included: Resident #2 was originally admitted to the facility on 6/30/18. Her diagnoses included Diabetes, chronic obstructive pulmonary disease, abnormal weight loss and anxiety disorder. The current care plan for Resident #2 with a revision date of 7/22/19 revealed she was at "risk for less than body requirement related to being on a therapeutic diet" due to diagnosis of diabetes. A progress note written by the Registered	F 657	"On 10/06/2021, LPN Liaison updated the care plan for resident # 2 to reflect significant weight loss. "On 10/20/2021, Administrator reviewed and revised facility policy Care Plans if applicable. "On 10/20/2021, Administrator initiated an in-service for facility MDS Coordinators to be conducted by Administrator/Designee on facility Care Plan policy focusing on ensuring that the care plan for each resident with significant weight loss is reviewed and updated at least quarterly. Any MDS Coordinator not in-serviced by 10/22/2021 will be prior to next scheduled shift.	

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F 657	Continued From page 7 Dietitian dated 5/26/21 revealed Resident #2 had a significant weight loss identified as 11.8 % loss in the last 6 months. The most recent quarterly MDS dated 7/1/21 indicated Resident #2 was cognitively intact. She was independent for locomotion and eating. She required limited assistance for dressing. She weighed 93 pounds, had no weight loss and was receiving a therapeutic diet. On 10/5/21 at 1:00 PM the consulting Registered Dietitian (RD) stated on 5/26/21 Resident #2 was started on no added sweets high calorie shakes 2 times per day. Then on 6/21/21 the no added sweets high calorie shakes were stopped because Resident #2 would not drink them. The RD said on 7/13/21 she noted Resident #2 was refusing many of her meals and supplements. On 9/8/21 Resident #2 was started on a high calorie commercial supplement 2 times per day. The RD added the intake of the supplement was documented on the medication administration record so she could see Resident #2 was consuming it. On 10/6/21 at 1:40 PM the Nurse Liaison stated the date of 7/22/19 was the last time the care plan for weight loss was updated because she was staffing a medication cart and attending school. She added weight loss and other concerns for all residents were discussed in the weekly morning meetings. On 10/6/21 at 2:15 PM the Director of Nursing stated weight loss was discussed in the daily interdisciplinary team meeting and/or during the case mix meeting each Wednesday. She said the care plan should have been updated.	F 657	"On 10/21/2021, Administrator initiated an audit to be conducted by MDS Coordinator/Designee on all in-house resident□s care plan that has significant weight loss to ensure the care plan has been reviewed and revised at least quarterly. Any care plan found to not be reviewed and revised quarterly will be immediately. Audit to be completed by 10/22/2021. "For continued monitoring, random selection of 25% of in-house resident□s care plan that has significant weight loss are to be audited by Director of Nursing/Designee to ensure the care plan has been reviewed and revised at least quarterly. Any care plan found to not be reviewed and revised quarterly will be immediately. Audit to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed MDS Coordinators will be educated during the orientation process on facility policy Care Plans focusing on ensuring the care plan for any resident with significant weight loss is reviewed and revised at least quarterly. "Results of all in-house resident Care Plan audits will be presented by Director of Nursing/Designee at the next scheduled Quality Assurance Committee meeting for review and again at the following quarterly Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide nail care for 1 (Resident #25) of 2 residents who was dependent on facility staff for activities of daily living (ADLs). The findings included: Resident #25 was admitted to the facility 11/14/18. His diagnoses included diabetes, stroke with right side hemiplegia, and right upper extremity contracture. The quarterly Minimum Data Set (MDS) dated 8/27/21 revealed Resident #25 was usually understood and he usually understands. He required extensive assistance with bed mobility. He was totally dependent for all other activities of daily living (ADLs) except he was coded as independent with eating. He had range of motion impairment on one side of both upper and lower extremity. He had no behaviors or rejection of care. Resident #25's care plan revised 12/10/19 indicated he required assistance with ADLs related to cognitive impairment, physical impairment of right upper extremity (RUE). He had a past medical history of stroke, generalized muscle weakness, contracture of right arm/hand and dementia. The intervention for bathing	F 677	"On 10/05/2021, nail care was provided to Resident #25. "On 10/05/2021, Administrator initiated an audit to be conducted by MDS Coordinator/Designee on all in-house residents to ensure nail care was provided. Any resident found to need nail care was provided the ADL care immediately. "On 10/07/2021, Administrator reviewed and revised if applicable facility policy Nail Care (Fingernails/Toenails) Procedure. "On 10/07/2021, Administrator initiated an in-service to all in-house nursing staff to be conducted by Director of Nursing/Designee on facility policy Nail Care (Fingernails/Toenails) Procedure focusing on ensuring nail care is provided to residents who are dependent on facility staff for ADL□s. Any in-house nursing staff not in-serviced by 10/10/2021 will be prior to next scheduled shift. "For continued monitoring, random selection of 25% of in-house residents are to be audited by Director of Nursing/Designee to ensure nail care is provided to all residents who are	10/25/21

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F 677	Continued From page 9 revealed he was dependent with aid of 1 person. The intervention for bed mobility revealed he needed assistance to turn and reposition/re-align in bed. On 10/3/21 at 12:48 PM Resident #25 was observed in his bed. An observation of his left hand revealed his fingernails contained black debris and the nails on his middle and ring finger were jagged. On 10/4/21 at 2:24 PM Nursing Assistant (NA) #2 stated she had given Resident #25 a bath. She stated today was the first time she had worked with Resident #25. NA #2 reported he assisted with his bath by washing his own face, ears, head, neck, and hands. She said she performed all the other tasks for his bath. On 10/5/21 at 3:00 PM Resident #25 was in his bed. An observation of his left hand revealed his fingernails continued to contain black debris and the nails on his middle and ring finger remained jagged. On 10/5/21 at 3:00 PM Resident #25 said he did not go out of his room to the shower room yesterday. He said he did receive a bath yesterday and again today. On 10/5/21 at 3:05 PM NA #3 stated cleaning fingernails was part of the daily bath. On 10/5/21 at 3:15 PM Nurse #1 stated she saw Resident #25's fingernails earlier that morning and noticed the nails on his left hand were dirty and jagged. During an observation on 10/5/21 at 3:35 PM,	F 677	dependent on facility staff for ADL care. Any resident found to need nail care will be provided the ADL care immediately. Audit is to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed nursing staff will be educated during the orientation process on facility policy Nail Care (Fingernails/Toenails) Procedure focusing on ensuring nail care is provided to all residents who are dependent on facility staff for ADL care. "Results of all in-house resident fingernail audits will be presented by Director of Nursing/Designee at the next scheduled Quality Assurance Committee meeting for review and again at the following quarterly Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	

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F 677	Continued From page 10 with Nurse #6, Resident #25 stated he did not receive a shower yesterday as scheduled. He said he received a bath on 10/4/21 and 10/5/21. On 10/5/21 at 3:35 PM Nurse #6 observed Resident #25's fingernails. She stated the nails on his left hand were dirty and he had jagged fingernails. She stated his nails should have been cleaned during his bath or his shower. Nurse #6 stated she was going to take him to the shower so she could clean his fingernails.	F 677		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide Registered Nurse coverage for at least 8 consecutive hours 7 days per week for 3 of 30 days reviewed. The findings included: A review of the daily nurse staff posting forms	F 727	"On 10/08/2021, Administrator posted a help wanted ad for Registered Nurse. "As of 10/13/2021, actively employed LPN Administration nurse scheduled NCLEX-RN with a test date of November 15, 2021 (Registration ID # 406321004)	11/1/21

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F 727	Continued From page 11 from 9/1/21 through 9/30/21 revealed the facility did not have the required Registered Nurse (RN) coverage for at least 8 consecutive hours on Saturday 9/25/21, Wednesday 9/29/21 and Thursday 9/30/21. On each of these days the census was 33. On 10/6/21 at 4:30 PM the Director of Nursing (DON) reported Nurse #6 worked as a RN until she found out on 9/23/21 she did not pass the board of nursing exam therefore, she could work as a Licensed Practical Nurse. The DON explained Nurse #5 was an RN, but another RN was required to be in the building whenever Nurse #5 worked. The DON said since 9/23/21 she was the only RN available, so she worked every day Nurse #5 worked. The DON indicated she took the day off when Nurse #5 was off which left the facility without RN coverage on some days. The DON confirmed there was no RN coverage on 9/25/21, 9/29/21 and 9/30/21.	F 727	"On 10/13/2021, Administrator submitted all required information to CMS for waiver of requirement to provide licensed nurses on a 24-hour basis because facility is located in a rural area that has on-call RN and Physicians available 24/7 and the facility along with the Medical Director has determined that the waived requirement will not endanger the health and safety of the residents (case number CS1438643). " On 10/26/2021, Administrator signed a contract with Florence Nursing Services to assist in providing the required Registered Nurse coverage for at least 8 consecutive hours, 7 days per week. "For continued monitoring, Administrator initiated an audit to be conducted by Director of Nursing/Designee to begin on 11/01/2021 of Licensed Nurse schedule weekly times 4 weeks and monthly thereafter to ensure facility provides Registered Nurse coverage for at least 8 consecutive hours, 7 days per week. "Results of audits and waiver will be presented by Director of Nursing/Designee at the next scheduled Quality Assurance Committee meeting for review and again the following Quarterly Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		10/25/21

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F 761	Continued From page 12 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and pharmacy interviews, the facility failed to discard expired medications in 2 of 2 medication carts, and narcotics in the narcotic lock box contained no expiration date in 1 of 2 medications carts. Findings Included: 1 a. On 10/05/2021 at 8:33 p.m., Nurse #3 was observed during a medication pass removing a bottle of bulk stock folic acid 1mg from medication cart	F 761	"On 10/05/2021, Nurse on duty discarded 2 of 2 expired medications. "On 10/05/2021, Director of Nursing contacted the VA pharmacy and obtained correct expiration date for narcotic with no expiration date. "On 10/05/2021, Administrator initiated an audit of all medication carts to ensure any expired medications were discarded and all medications contained an expiration	

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F 761	Continued From page 13 #1 and removing one pill from the folic acid bottle and placing the pill in a medication cup during a medication administration pass. The bottle of bulk stock folic acid was observed with two expirations dates: the expiration date on the manufacture ' s bottle was 9/2021 and the pharmacy label expiration date was 11/15/2021. After Nurse #3 was asked which expiration date was used, she answered, "I don't know" and removed the folic acid pill in the medication cup and discarded the medication in the trash. Nurse #3 removed the bottle of bulk stock folic acid from medication Cart #1. On 10/5/2021 at 9:07a.m. in an interview with Nurse #3, she stated she was not sure who was responsible for checking the medication cart #1 for expired medications. She stated nurses checked the expiration dates of medications before administering medications to the residents. On 10/5/2021 at 9:40 a.m. in an interview with the Director of Nursing, she stated the night shift nurses checked the medication carts for expired medications, and the pharmacy checked the medication carts monthly. She stated if a bottle of medication had two different expiration dates, one on the bottle and the pharmacy label, the nurses used the expiration date on the pharmacy label. She further stated expired bottles of medications were to be discarded. On 10/5/2021 at 10:13 a.m. in an interview with	F 761	date. Audit completed on 10/05/2021 "On 10/05/2021, Administrator reviewed and revised if applicable facility policy Labeling and Storage of Medications. "On 10/05/2021, Administrator initiated an in-service to be conducted by Director of Nursing/Designee for all licensed staff on facility policy Labeling and Storage of Drugs, F761 □ Labeling of Drugs and Biologicals, and FDA frequently asked questions for Expiration Dates focusing on ensuring all medications have an expiration date and discarding any expired medications. Any licensed staff not in-serviced by 10/07/2021 will be prior to next scheduled shift. "On 10/20/2021, Pharmacy QA Account Manager audited one of two medication carts to ensure all medications have an expiration date and any expired meds were discarded. The second cart is scheduled for Pharmacy QA audit in November 2021. "For continued monitoring, Administrator initiated an audit to be conducted by Director of Nursing/Designee on all medication carts to ensure any expired medications were discarded and all medications contained an expiration date. Audit to continue weekly times 4 weeks and monthly thereafter. "All newly employed Licensed staff will be educated by Human Resources/Designee during the orientation process on facility	

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F 761	Continued From page 14 the facility's pharmacist, he stated the manufacture's expiration on the bottle was when the medication expired, and nurses were to use the manufacture's expiration date on the bottle for the medications with different expiration dates on the bottle and the pharmacy label. He stated the pharmacy placed a six month expiration date on medications dispensed from the pharmacy, and the expiration date on the pharmacy label should have been marked out since the bottle had an expiration date. He stated that was a pharmacy error, and an expiration date should not have been on the label. He stated pharmacy technicians or nurses checked the medication carts every other month for expired medications and recommended the facility staff to check medications for expiration dates also. The pharmacist stated he did not know when the medications carts were last checked by the pharmacy staff. b. On 10/5/2021 at 9:27 a.m., a bottle of bulk stock B-12 100 micrograms with expiration date 8/2021 was observed in the top drawer of medication cart #2. A bottle of bulk stock Certovite Seniors was also observed in the top drawer of medication cart #2 with two expiration dates: 9/2021 was on the bottle and an expiration date 4/2022 was on the pharmacy label.	F 761	policy Labeling and Storage of Medications focusing on ensuring all medications have an expiration date and discarding any expired medications. "Results of all medication cart audits will be presented by Director of Nursing/Designee at the next scheduled Quality Assurance Committee meeting for review and again at the following Quality Assurance Committee meeting for determination at that time for continued need for monitoring.	

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On 10/5/2021 at 9:27 a.m. in an interview with Nurse #4, she stated she did not know why the pharmacy expiration date was different than the bottle expiration date, but she would use the pharmacy expiration date. She further stated the medication cart was checked every shift for expired medications and any expired medications were discarded.

On 10/5/2021 at 9:40 a.m. in an interview with the Director of Nursing, she stated the night shift nurses checked the medication carts for expired medications, and the pharmacy checked the
medication carts monthly. She stated if a bottle of medication had two different expiration dates, one on the bottle and the pharmacy label, the nurses used the expiration date on the pharmacy label. She further stated expired bottles of medications needed to be discarded.

On 10/5/2021 at 10:13 a.m. in an interview with the facility's pharmacist, he stated the manufacture's expiration on the bottle was when the medication expired, and nurses were to use the manufacture's expiration date on bottles of medications with different expiration dates:
one on the bottle and one on the pharmacy label. He stated the pharmacy placed a six month expiration date on medications dispensed from the pharmacy, and the expiration date on the pharmacy label should have been marked out since the bottle had an expiration date. He stated that
was a pharmacy error, and an expiration date should not have been on the label. He stated the pharmacy technician or nurse checked the medication carts every other month for expired

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F 761	Continued From page 16	F 761		

medications and recommended the facility staff to check medications for expiration dates also. The pharmacist stated he did not know when the medications carts were last checked by the pharmacy staff.

2. On 10/5/2021 at 9:07a.m., a bottle of Hydrocodone/Acetaminophen 5 milligram (mg)/325 mg, a bottle of Lorazepam 1 mg and a bottle of Norco-5 Hydrocodone 5/325mg for Resident #6 was found in the locked narcotic box on medication cart #1 without expiration dates.

On 10/5/2021 at 9:07a.m. in an interview with Nurse #3, she stated Resident #6's son filled her prescriptions at the pharmacy on the military base and was unable to locate an expiration date on the three bottles of medications or the pharmacy label. Nurse #3 stated nurses checked the expiration dates of medications before administering medications to the residents.

On 10/5/2021 at 9:40 a.m. in an interview with the Director of Nursing, she stated the medications needed an expiration date on the bottle or label.

On 10/5/2021 at 10:13 p.m. in a phone interview with the facility's pharmacist, he stated the medications filled from the military base for Resident #6 required an expiration date on the

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F 761	Continued From page 17 label. On 10/6/2021 at 8:15 a.m. in an interview with the military pharmacist, she stated the label may not have an expiration date if filled by the staff instead of a robot, and prescriptions expired six months after the dispensed date. The Director of Nursing requested the military pharmacist to submit a label for the medications with an expiration date.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801		11/18/21

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supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for

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F 801	Continued From page 19 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on record review and staff and consulting Dietitian interviews the facility failed to employ a clinically qualified nutritional professional on a full time basis when the currently employed dietary manager's certificate was expired. The affected 33 of 33 resident who received meals from the dietary department. The findings included: During an interview with the Dietary Manager on 10/4/21 at 4:20 PM she stated she was not currently a certified dietary manager because her certificate expired. She stated she had worked at the current facility for the last 2 years. A review of the certificate from the Certifying Board for Dietary Managers provided by the Dietary Manager revealed it expired on 8/31/19. During an interview with the Registered Dietitian on 10/5/21 at 11:30 AM she stated she visited the facility monthly as the consulting dietitian. She said she was responsible for the clinical nutrition concerns such as weight loss, tube feedings and wounds. She said the Dietary Manager called her with things the Dietary Manager had questions about.	F 801	"On 10/08/2021, facility Dietary Manager received Certified Servsafe Instructor and Registered ServSafe examination Proctor certification. "On 10/11/2021, Dietary Manager applied for Certified Dietary Manager certification (Application ID: 240118). "On 10/12/2021, Administrator, Dietician and all dietary staff received ServSafe certification. "On 10/20/2021, Administrator initiated an in-service to be conducted by Administrator/Designee on facility policy Director of Food and Nutrition Services specific to ensuring Certified Dietary Manager certification is always maintained, current and on file in the employee personnel file. "On 10/28/2021, Dietary Manager received confirmation that Certified Dietary Manager Credentialing Examination is scheduled for 11/18/2021 at 9:00am (confirmation # SC4667854) "For continued monitoring, Administrator/Designee will audit all Dietary certifications yearly to ensure	

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F 801	Continued From page 20	F 801	certifications are always maintained and current. "All newly employed Dietary Managers will be educated during the orientation process on facility policy Director of Food and Nutrition Services focusing on ensuring Certified Dietary Manager certification is always maintained, current and on file in the employee personnel file. "Results of yearly Dietary Certifications will be presented by Administrator/Designee at the next scheduled Quality Assurance Committee Meeting for review with determination at that time for continued need for monitoring.	
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 803		10/29/21

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F 803	Continued From page 21 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff and consulting Dietitian interviews, and record review the facility failed to have planned menus which included the correct foods and portions for the dietary staff to serve for 2 of 2 meal observations. This practice resulted in incorrect foods being served to residents. The findings included: A review of the Week 4 Spring Summer 2021 menu provided by the facility revealed on day 2 (Tuesday 10/5/21) the breakfast meal was fried egg patty, sausage link, cold cereal, toast/jelly, juice milk, coffee. There were no portions sizes or clarifications for therapeutic diets. A review of the Day 2 Week 4 menu (Tuesday 10/5/21) spread sheet approved by the consulting Registered Dietitian revealed a breakfast menu of 4 ounces of assorted juice. For renal diet it read apple or CB (cranberry) only. The spread sheet also listed egg & cheese on English muffin 1 each, cereal of choice 4 ounces, fresh fruit 4 ounces (renal listed 4 ounces applesauce), margarine & syrup 1 each [NCS (no concentrated sweets) listed 1 each SF (sugar free) syrup], milk 2% 8 ounces, coffee 8 ounces and water 8	F 803	"On 10/22/2021, facility Dietician provided planned menus which include the correct foods and portion sizes to ensure adequate amounts at each meal is served to satisfy recommended daily allowances. "On 10/22/2021, Administrator initiated an in-service to be conducted by Dietary Manager/Designee for all facility dietary staff on planned menus ensuring they are followed each meal to ensure adequate amounts at each meal is served to satisfy recommended daily allowances. Any employee not in-serviced by 10/25/2021 will be prior to next scheduled shift. "On 10/22/2021, Administrator initiated an audit to be conducted by Administrator/Designee on observation of meals to ensure planned menus were followed to ensure adequate amounts at each meal is served to satisfy recommended daily allowances. Audit is to continue for 7 days with a completion date of 10/29/2021. "For continued monitoring, random selection of 3 meals per week to be	

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F 803	Continued From page 22 ounces. A review of the current diet manual used by the Dietary Manager dated January 2019 revealed on page 98 a list of miscellaneous items under foods included for the Limited Concentrated Sweets (LCS) diet included "low calorie diet syrup." Under foods excluded was regular syrup. During an observation of the breakfast meal on 10/05/21 at 8:00 AM an observation of a meal tray delivered to a resident revealed the meal tray ticket was present on the tray. It read Regular, LCS, fruit for dessert. The tray included a 1.5 ounce container of regular syrup. During an observation of the breakfast meal on 10/05/21 at 8:05 AM the meal tray revealed a tray ticket which read regular, liberal renal, LCS, Low Potassium diet. The tray included scrambled eggs, 1 link sausage, ½ cup of grits, 2 French toast sticks, 1 whole banana, a 1.5 ounce container of regular syrup, a 4 ounce container of grape-cranberry juice, 2 packets of artificial sweetener and 2 packets of salt. On 10/5/21 at 11:15 AM the Dietary Manager stated the dietary staff prepped the lunch trays first beginning at 11:00 AM and the tray line started at 11:30 AM. She said today was "Taco Tuesday". On 10/5/21 at 11:45 AM an observation of the lunch tray line revealed the food items included taco meat, Spanish rice, pinto beans with cheese on top. Raw diced tomatoes and lettuce were in containers separate from the hot food items. The dessert of banana pudding was already in serving bowels on the trays.	F 803	audited by Administrator to ensure planned menus are followed each meal to ensure adequate amounts at each meal is served to satisfy recommended daily allowances. Audit to continue for 4 weeks and monthly thereafter. "All newly employed Dietary staff will be educated during the orientation process on facility policy Menu Planning focusing on ensuring planned menus are followed to ensure adequate amounts at each meal is served to satisfy recommended daily allowances. "Results of Dietary audits will be presented by Administrator/Designee at the next scheduled Quality Assurance Committee meeting and again at the following Quality Assurance Committee Meeting with determination at that time for continued need for monitoring.	

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An observation of the menu provided by the Dietary Manager revealed the Week 4 Tuesday (day 2) lunch menu was taco salad, lettuce/tomato, sour cream, Spanish rice, pinto and cheese, strawberry shortcake. There were no portion sizes listed and no information for therapeutic diets on the menu.

A review of the Day 2 Week 4 menu spread sheet approved by the consulting Registered Dietitian revealed the lunch menu was oven fried chicken 4 ounces, corn casserole 4 ounces, coleslaw 4 ounces, cheesecake 1 slice, dinner roll 1 each, and iced tea 8 ounces.

During an interview with the Dietary Manager on 10/4/21 at 4:22 PM she stated there were no spread sheets for the current menu to tell the dietary staff what food items each diet was to receive. She said the menu spread sheets were not needed "because all the residents get the same foods." She added there was only 1 resident on a renal diet and 1 resident on a diabetic diet.

On 10/5/21 at 12:51 PM the consulting Registered Dietitian stated she did not have spread sheets for the current menu, but the Dietary Manager had portion control serving utensils and knew what to serve. She stated a NCS diet should receive 2 starches, 1 milk, 1 fruit and 2 ounces of protein at breakfast. She added ½ of a regular size banana was the correct portion of fruit for a LCS diet. She said the NCS diet should receive only sugar free syrup. She then added a resident on a renal diet should not receive any portion of banana and they should receive cranberry juice not grape-cranberry. She

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F 803	Continued From page 24 also stated residents on a NAS diet should not receive salt packets. During an interview with the Dietary Manager on 10/6/21 at 9:40 AM she stated she did not know until after the meal was served that all the residents received regular syrup. She said the residents could just get more insulin if needed. The Dietary Manager said if she knew before the meal was served, she would have purchased sugar free syrup from the local grocery store so it would be available for the breakfast meal. She also said they facility changed food service vendors 3 months ago and the current vendor did not carry some of the healthcare food items she needed for diet restrictions because they were not familiar with the needs of healthcare accounts.	F 803		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff and consulting Dietitian interviews, and record review the facility failed to serve therapeutic diets as ordered by the physician for 2 of 2 residents (Resident #11 and Resident #2) reviewed for nutrition.	F 808	"On 10/05/2021 and 10/06/2021, for resident #11 and resident #2, facility reviewed vitals report and Dialysis communication sheet that shows residents did not have any adverse effect to incorrect diet served.	10/25/21

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F 808	Continued From page 25 The findings included: 1. Resident #11 was admitted to the facility on 1/10/13. Her diagnoses included diabetes, end stage renal disease, hemodialysis, congestive heart failure and hyperkalemia. The quarterly minimum data set dated 7/28/21 revealed Resident #11 was cognitively intact. She was independent with eating. She received insulin injections for 7 days of the look back period. She received dialysis. Resident #11's active care plan revised on 08/6/19 revealed she was at risk for complications due to hemodialysis. One of the interventions was "Provide diet as ordered." A review of the physician orders for October 2021 revealed a diet order which read, Renal diet regular texture NAS (No added Salt), NCS (No concentrated sweets) mighty shakes with meals. During an interview with the Dietary Manager on 10/4/21 at 4:22 PM she stated there were no spread sheets for the current menu to tell the dietary staff what food items each diet was to receive. She said the menu spread sheets were not needed "because all the residents get the same foods." She added there was only 1 resident on a renal diet and 1 resident on a diabetic diet. During an observation of the breakfast meal on 10/05/21 at 8:05 AM Resident #11's meal tray included 1 whole banana, a 1.5 ounce container of regular syrup, a 4 ounce container of grape-cranberry juice and 2 packets of salt.	F 808	"On 10/21/2021, Administrator reviewed and revised if applicable facility Policy Therapeutic Diets. "On 10/21/2021, Administrator initiated an in-service to be conducted by Dietary Manager/Designee for all dietary staff on facility policy Therapeutic Diets specific to ensuring therapeutic diets are followed to meet the clinical needs of the resident. Any staff not in-serviced by 10/25/2021 will be prior to next scheduled shift. On 10/22/2021, Dietary Manager created a binder to include planned menus which include the correct foods and portion sizes to ensure adequate amounts at each meal is served to satisfy recommended daily allowances. Binder is to be located in the kitchen available to dietary staff. "On 10/22/2021, Administrator initiated an audit to be conducted by Dietary Manager/Designee for all in-house resident□s diet orders and tray card tickets to ensure they coincide. Audit is to be complete 10/22/2021. "On 10/22/2021, Administrator initiated an audit to be conducted by Dietary Manager/Designee on observation of meals to ensure therapeutic diets are followed to meet the clinical needs of the resident. Audit is to continue for 7 days with a completion date of 10/29/2021. "For continued monitoring, random selection of 25% of meals are to be	

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F 808	Continued From page 26 On 10/5/21 at 12:51 PM the consulting Registered Dietitian stated she did not have spread sheets for the current menu, but the Dietary Manager had portion control serving utensils and knew what to serve. She stated a NCS diet should receive 2 starches, 1 milk, 1 fruit and 2 ounces of protein at breakfast. She added ½ of a regular size banana was the correct portion of fruit for a NCS diet. She then added a resident on a renal diet should not receive any portion of banana and they should receive cranberry juice not grape-cranberry. She also stated residents on a NAS diet should not receive salt packets. 2. Resident #2 was admitted to the facility on 6/30/18. Her diagnoses included Diabetes, chronic obstructive pulmonary disease, abnormal weight loss and anxiety disorder. The current care plan for Resident #2 with a revision date of 7/22/19 revealed she had potential for complications of hypo/hyperglycemia due to diabetes. The interventions included provide diet and food preferences. A review of the current diet manual used by the Dietary Manager dated January 2019 revealed on page 98 a list of miscellaneous items under foods included for the Limited Concentrated Sweets (LCS) diet included "low calorie diet syrup." Under foods excluded was regular syrup. The quarterly MDS dated 7/1/21 indicated Resident #2 was cognitively intact. She was independent for locomotion and eating. She received a therapeutic diet. A review of the October 2021 physician orders	F 808	audited by Administrator/Designee to ensure Therapeutic diet orders are followed to meet the clinical needs of the resident. Audit to continue weekly times 4 weeks to total 100% and monthly thereafter. "All newly employed Dietary staff will be educated during the orientation process on facility policy Therapeutic Diets focusing on ensuring therapeutic diets are followed to meet the clinical needs of the resident. "Results of Dietary audits will be presented by Administrator/Designee at the next scheduled Quality Assurance Committee meeting and again at the following Quality Assurance Committee Meeting with determination at that time for continued need for monitoring.	

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F 808	Continued From page 27	F 808		

revealed an order of Low concentrated sweets diet with regular texture.

During an interview with the Dietary Manager on 10/4/21 at 4:22 PM she stated there were no spread sheets for the current menu to tell the dietary staff what food items each diet was to receive. She said the menu spread sheets were not needed "because all the residents get the same foods." She added there was only 1 resident on a renal diet and 1 resident on a diabetic diet.

During an observation of the breakfast meal on 10/05/21 at 8:00 AM Resident #2 was observed to receive regular syrup on her meal tray. Her meal tray ticket was present on her tray. It read Regular, LCS, fruit for dessert.

On 10/5/21 at 12:51 PM the consulting Registered Dietitian stated she did not have spread sheets for the current menu, but the Dietary Manager had portion control serving utensils and knew what to serve. She stated a NCS diet should receive 2 starches, 1 milk, 1 fruit and 2 ounces of protein at breakfast. She added the NCS diet should not receive regular syrup.

During an interview with the Dietary Manager on 10/6/21 at 9:40 AM she stated she did not know until after the meal was served that all the residents received regular syrup. She said the residents could just get more insulin if needed. The Dietary Manager said if she knew before the meal was served, she would have purchased sugar free syrup from the local grocery store so it would be available for the breakfast meal. She also said the facility changed food service vendors 3 months ago and the current vendor did

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F 808	Continued From page 28 not carry some of the healthcare food items she needed for diet restrictions because they were not familiar with the needs of healthcare accounts.	F 808		
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 observations and staff and consulting Dietitian interviews the facility failed to: 1) to maintain items in the freezer in a solid frozen state, 2) label or date opened food items in the reach in cooler and 3) serve pudding dessert less than 41 degrees during 2 of 2 kitchen observations. The findings included:	F 812	•On 10/20/2021, Kennedy Refrigeration adjusted thermostat in walk in freezer to maintain a temp of 0 degrees or below to ensure food items are frozen solid. •On 10/22/2021, Administrator reviewed and revised if applicable facility policy “Food Storage” and “Food Temperatures”. •On 10/22/2021, Administrator initiated an	10/25/21

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F 812	Continued From page 29 1. During an observation of the walk in freezer on 10/3/21 at 11:40 AM a sealed bag of waffles, a bag of soup, a box of French fries, a box of name brand individually packaged peanut butter and jelly sandwiches, and a bag of okra were soft and pliable when touched. An observation of the thermometer inside the freezer revealed the temperature was 22 degrees Fahrenheit. During the observation on 10/3/21 at 11:40 AM Dietary Aide #1 stated the items in the freezer were usually soft and not frozen solid. An observation of the thermometer inside the freezer revealed the temperature was 22 degrees Fahrenheit. During an observation on 10/05/21 at 4:30 PM with the Dietary Manager the breaded okra was observed to be soft to the touch. The individual pieces were pliable and not solid. The dietary manager stated she could contact maintenance to check the freezer. On 10/5/16 at 5:15 PM the Administrator stated the freezer was at 22 degrees. She stated since the food items were not frozen it put her residents at risk. 2. During the observation of the reach in refrigerator on 10/3/21 at 11:45 AM an open package of shredded cheddar cheese, an open package of waffles and an open package of sliced ham were not labeled or dated. During the observation on 10/3/21 at 11:45 AM Dietary Aide #1 stated all opened items should have a date on them. During an interview with the Registered Dietitian	F 812	in-service to be conducted by Dietary Manager/Designee for all dietary staff on facility policy “Food Storage” and “Food Temperatures” focusing on (A) foods should be covered, labeled and dated and routinely monitored to assure that foods will be consumed by their safe use by dates or discarded, (B) Frozen foods must be maintained at a temperature to keep the food frozen solid, (C) Foods served will maintain temperatures at or below 41 degrees for cold foods and at or above 135 degrees for hot foods. Any Dietary staff not in-serviced by 10/25/2021 will be prior to next scheduled shift. •On 10/22/2021, Administrator initiated an audit to be conducted by Dietary Manager/Designee on ensuring refrigerator and freezers are checked daily to ensure foods are covered, labeled, and dated and routinely monitored to assure that foods will be consumed by their safe use by dates or discarded. Audit to continue daily. •On 10/22/2021, Administrator initiated an audit to be conducted by Dietary Manager/Designee on monitoring freezer temperatures two times a day to ensure frozen foods are maintained at a temperature to keep the food frozen solid. Audit to continue two times a day. •On 10/26/2021, Administrator initiated an audit to be conducted by Dietary Manager/Designee on food temperatures served to ensure temperatures are maintained at or below 41 degrees for	

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F 812	Continued From page 30 on 10/5/21 at 12:55 PM she stated opened food items should be dated with either an open date or a use by date. 3. During an observation of the lunch meal service on 10/5/21 at 11:45 AM the banana pudding had a temperature of 62 degrees. On 10/5/21 at 4:41 PM the Dietary Manager stated she made the banana pudding that morning using canned banana pudding, mini vanilla wafers and nondairy whipped topping. She said she mixed all the ingredients together then put the servings in individual bowls, put the bowls on pans then placed them in the refrigerator. She then said the individual bowls were in the refrigerator approximately 1 hour prior to then placing them on the residents' trays. The Dietary Manager again stated she used nondairy topping and canned pudding.	F 812	cold foods and at or above 135 degrees for hot foods. Food items will be checked each meal. •For continued monitoring, refrigerators and freezers will be checked weekly by Administrator/Designee to ensure foods are covered, labeled and dated and routinely monitored to assure that foods will be consumed by their safe use by dates or discarded. Audit to continue weekly times 4 weeks and monthly thereafter. •For continued monitoring, freezer temperatures will be checked weekly by Maintenance Director/Designee to ensure frozen foods are maintained at a temperature to keep foods frozen solid. Audit to continue weekly times 4 weeks and monthly thereafter. •For continued monitoring, audit on food temperatures served will be checked by Administrator/Designee weekly to ensure temperatures are maintained at or below 41 degrees for cold foods and at or above 135 degrees for hot foods. Audit to continue weekly times 4 weeks and monthly thereafter. •All newly employed Dietary staff will be educated during the orientation process on facility policy “Food Storage” and “Food Temperatures” focusing on (A) foods should be covered, labeled and dated and routinely monitored to assure that foods will be consumed by their safe use by dates or discarded, (B) Frozen	

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F 812	Continued From page 31	F 812	foods must be maintained at a temperature to keep the food frozen solid, (C) Foods served will maintain temperatures at or below 41 degrees for cold foods and at or above 135 degrees for hot foods. •Results of food storage, freezer temperature checks and food temperatures served will be presented by Administrator/Designee at the next scheduled Quarterly Quality Assurance Committee meeting and again the following Quality Assurance Committee meeting for determination at that time for continued need for monitoring.	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, record review and facility staff interviews the facility failed to maintain bed rails in good repair for 1 (Resident #25) of 1 resident's bed rails observed with the manufactured covering missing. The findings included: Resident #25 was admitted to the facility 11/14/18. His diagnoses included diabetes, stroke, and right upper extremity contracture. The quarterly Minimum Data Set (MDS) revealed	F 921	"On 10/06/2021, facility Maintenance Director replaced the bed for resident #25 to ensure the bed rails were safe, functional, sanitary, and comfortable. "On 10/07/2021, Administrator conducted an in-service to Maintenance Director focusing on bed rails to ensure the facility provides a safe, functional, sanitary, and comfortable environment to all residents. "On 10/07/2021, Administrator initiated an audit to be conducted by Maintenance	10/14/21

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F 921	Continued From page 32 Resident #25 was usually understood and he usually understands. He required extensive assistance with bed mobility. He was totally dependent for all other activities of daily living (ADLs) except he was coded as independent with eating. He had range of motion impairment on one side of both upper and lower extremity. Resident #25's care plan revised 12/10/19 indicated he required assistance with ADLs related to cognitive impairment, physical impairment of right upper extremity (RUE), Right below knee amputation. He had a past medical history of stroke, generalized muscle weakness, contracture of right arm/hand and dementia. The intervention for bathing revealed he was dependent with aid of 1 person. The intervention for bed mobility revealed he needed assistance to turn and reposition/re-align in bed. May require more supportive assistance at times. An observation of Resident #25's room on 10/03/21 at 12:56 PM revealed 12 inches of the metal support bar was exposed on right side bed rail. The factory foam padding was missing which caused the metal support to be exposed. The metal support bar was not jagged and had no sharp edges. The edges of the broken factory padding had no sharp edges. The left side bed rail was taped for 10 - 12 inches with black electrical tape along the lower edge of the top part of the bed rail. An observation of Resident #25's room on 10/5/21 at 3:00 PM revealed the right bed rail was visible from the resident's door but the left rail could not be easily seen because the over the bed table was obstructing the visualization of that rail from the doorway. Upon entrance to the room	F 921	Director/Designee on all facility bed rails to ensure the facility provides a safe, functional, sanitary, and comfortable environment to all residents. Audit to be completed on 10/07/2021. "For continued monitoring, random audit of 25% of facility bed rails will be inspected by Administrator/Designee to ensure the facility provides a safe, functional, sanitary, and comfortable environment to all residents. Audit to continue weekly times 4 weeks and monthly thereafter. "All newly employed Maintenance staff will be educated during the orientation process on ensuring the facility provides a safe, functional, sanitary, and comfortable environment to all residents specific to inspection of bed rails. "Results of bed rail audit will be presented by Administrator/Designee to the next Quarterly Quality Assurance Committee meeting and again the following Quarterly Quality Assurance Committee meeting with determination at that time for continued need for monitoring.	

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BROOK STONE LIVING CENTER	8990 HIGHWAY 17 SOUTH POLLOCKSVILLE, NC 28573

(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
F 921	Continued From page 33 both rails could be seen. On 10/6/21 at 3:22 PM Nursing Assistant (NA) #1 stated today was the first time she had worked with Resident #25. She said she could see the right side bed rail from the Resident's doorway. She said there was metal exposed on the rail for about 12 inches. NA #1 said if she saw anything that needed to be repaired, she would inform one of the maintenance staff or would write it in the maintenance request logbook at the nursing station. During an observation of Resident #25's room on 10/6/21 at 3:40 PM Maintenance staff #1 stated he did not know the bed rail looked like that and no one told him. He stated he had previously put padding and black electrical tape on the left rail, but he did not know the right rail had metal showing. He stated replacement bed rails were "hard to come by." He added he did not go by every room on a regular basis, and he would expect to be told about a damaged bed rail.	F 921		