| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| PETTIGREW REHABILITATION CENTER | 1515 W PETTIGREW STREET DURHAM, NC 27705 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 2/6/23 through 2/9/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XEYK11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 2/6/23 through 2/9/23. Event ID# XEYK11. The following intakes were investigated: NC00193902, NC00194684, NC00195709, NC00196477, NC00196665, NC00196689 and NC00196855 . Twenty-four (24) of the 24 complaint allegations did not result in deficiency. | F 000 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon | F 690 | | 3/9/23 |

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

Electronically Signed | 03/01/2023

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| F 690 | Continued From page 1<br>as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview the facility failed to ensure a resident's urinary catheter drainage bag was secured in a manner to keep it off the floor or below the level of the bladder for 2 of 2 residents observed with indwelling urinary catheters (Resident #66 and Resident #37).<br><br>Findings included:<br><br>1. Resident #66 was admitted to the facility on 12/12/22 with diagnoses of overactive bladder, benign prostatic hyperplasia and urinary retention.<br><br>The admission Minimum Data Set (MDS) dated 12/19/22 assessed Resident #66 as cognitively impaired. He required one person assistance with personal hygiene and had an indwelling catheter.<br><br>A review of the care plan dated 12/12/22 revealed staff were to check tubing for kinks each shift and | F 690 | F 690 - Bowel/Bladder Incontinence, Catheter<br><br>This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law.<br><br>The affected residents foley catheter was secured, placed below the waist, and removed from touching the floor, 2/6/2023 by the licensed nursing staff.<br><br>Residents with foley catheters have the potential to be affected. 100% audit of all residents with foley catheters was performed by the Regional Clinical | |

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| F 690 | Continued From page 2<br>as needed and keep drainage bag covered, position/secure tubing to prevent traumatic removal.<br><br>Observation and interview was conducted on 2/06/23 at 10:23 AM, Resident #66's catheter drainage bag and the tubing was on the floor under the left side of resident's bed on a towel. The catheter could be seen from the hallway as staff passed by resident's room. The catheter drainage bag was not attached to the bed. Resident #66 stated the catheter drainage bag had been on the floor over the weekend. Resident #66 further stated staff acted like it was no big deal for it to be on the floor. It would pull sometime when he moved the covers. Staff stated they did not have the clips for the catheter drainage bag to place the bag in the right position below the bladder.<br><br>An interview was conducted on 2/6/23 at 10:24 AM. Nurse Aide #1 entered the room and stated the catheter drainage bag should not be on the floor. She stated she did not know who placed the catheter in this position.<br><br>An interview was conducted on 2/6/23 at 10:28 AM. Nurse #1 stated the catheter drainage bag should not have been placed on the floor. Nurse #1 stated the weekend nurses did not have access to the supply closet to get the proper clips for the catheter.<br><br>An interview was conducted on 2/6/23 at 10:28 AM, Nurse #2 confirmed the catheter drainage bag was on the floor. Nurse #2 stated the weekend nurses did not have access to the supply closet to obtain needed supplies. Nurse #2 stated the concern about lack of access to the | F 690 | Director on 2/6/2023. No issues were identified. All residents with Foley catheters were secure, below the waist, and not touching the floor.<br><br>To prevent this from recurring, the Director of Nursing/designee reeducated all clinical staff on the expectation that any resident with a foley catheter must be secured, below the waist, and not touching the floor. This education was completed on 2/17/23.<br><br>Any clinical/agency staff that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Director of Nursing/ designee.<br><br>Agency staff and newly hired licensed staff will have this education during their orientation period by the Director of Nursing/designee.<br><br>To monitor and maintain ongoing compliance, the Director of Nursing or designee will monitor all residents with foley catheters to ensure the catheter is secure, below the waist, and not touching the floor.<br><br>Monitoring will occur 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then weekly for 4 weeks.<br><br>The Director of Nursing will report the results of the monitoring to the QAPI committee for review and | |

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| F 690 | Continued From page 3<br>supply closet had been discussed with the Unit Manager on several occasions, however, there had been no response in allowing weekend staff access to the supply closet for items like catheters and/or urinary bag covers.<br><br>An observation was conducted on 2/6/23 at 10:36 AM, Nurse Aide #2 stated she was assigned to the room. The Nurse Aide #2 emptied the catheter and placed the catheter drainage bag back on the floor with a towel under it. She stated the clip on the top of the bag was broken and she would have to speak with nursing about it. When asked how long the clip had been broken and the urinary drainage bag placed on the floor, there was no response. She stated she should not have returned the catheter to the floor after it was emptied.<br><br>An observation was done on 2/6/23 at 11:00 AM. Nurse #3 observed the catheter drainage bag on the floor under the resident's bed. Nurse #3 confirmed the catheter was positioned incorrectly. The catheter bag should be below the bladder and secured to bed. Nurse #3 stated she would follow up with the Director of Nursing about nursing staff access to the supply room on the weekends.<br><br>An interview was conducted on 2/7/23 at 11:15 AM. The Director of Nursing (DON) stated the catheter should be below the bladder and secured to resident bed. The tubing nor the bag should be dragging or placed on the floor. She further stated she had been made aware on 2/6/23 the supply closet was locked over the weekend and nursing could not get the needed supplies for the catheter. | F 690 | recommendations for the time frame of the monitoring period or as it is amended by the committee.<br><br>Will be reviewed monthly for 100% compliance for 4 months. | |

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| F 690 | Continued From page 4 | F 690 | | |

2. Resident #37 was admitted to the facility on 12/1/22 with diagnoses of benign prostatic hyperplasia, urinary retention, and urinary tract infection.

The admission Minimum Data Set (MDS) dated 1/31/23 assessed Resident #37 was cognitively impaired. He required one person assistance with personal hygiene and had an indwelling catheter. The resident was coded as having a urinary tract infection in the last 30 days.

A review of the care plan dated 12/12/22 revealed staff were to check tubing for kinks each shift and as needed and keep drainage bag covered, position/secure tubing to prevent traumatic removal.

An observation and interview was conducted on 2/06/23 at 10:21 AM. Resident #37's catheter drainage bag tubing was observed on the floor under the bed at the foot of the bed unattached. Staff were observed walking past the resident's room, looking in room, but did not stop to pick up the catheter drainage bag from the floor. Resident #37 stated staff don't really check the catheter position unless they were going to empty it.

An observation was conducted on 2/8/23 at 9:17 AM. Resident #37 was lying in bed in a supine (lying face up) position and the catheter drainage bag was positioned on the bed near the resident's left elbow. The catheter bag was not positioned below the bladder. The catheter had a back flow valve to stop the urine going back up.

An observation on 2/6/23 at 11:00 AM, Nurse #3 observed the catheter drainage bag on the floor

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| F 690 | Continued From page 5<br>under the resident's bed. Nurse #3 confirmed the catheter was positioned incorrectly and should have been placed below the bladder. Nurse #4 stated she would follow up with Director of Nursing about nursing staff access to the supply room on the weekends.<br><br>An interview was conducted on 2/7/23 at 11:15 AM, the Director of Nursing (DON) stated the catheter should be below the bladder and secured to the bedframe. The tubing nor the bag should be dragging or placed on the floor. She further stated she had been made aware on 2/6/23 the supply closet was locked over the weekend and nursing could not get the needed supplies for the catheters. | F 690 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><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. | F 812 | | 3/9/23 |

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| F 812 | Continued From page 6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and an interview with the service technician for the facility's dish machine, the facility failed to: 1) Maintain the chemical sanitizing solution of the dish machine at the correct concentration according to the manufacturer's recommendations during 1 of 1 observations of the dish washing process; 2) Failed to change gloves/wash hands between handling soiled and clean dishes to prevent cross-contamination of the clean dishes and failed to allow all clean dishware to air dry during 1 of 1 observations of the dish washing practices; and 3) Dispose of expired food items and seal, label, and/or date opened food items observed in food storage areas during 2 of 2 observations of the facility's food storage areas.<br><br>The findings included:<br><br>1. Accompanied by the facility's Dietary Manager, a continuous observation was conducted on 2/8/23 from 1:10 PM to 1:20 PM of the facility's dish washing process using a low temperature dish machine. Upon request, the Dietary Manager tested the concentration of the dish machine's sanitizing solution by using chlorine test strips. The vial containing the test strips indicated the strips detected chlorine from 0 to 200 parts per million (ppm) by undergoing a color change. The Dietary Manager tested the sanitizing solution of the machine three times using three different test strips. None of the test strips changed color (indicative of low or no levels of chlorine in the solution). He reported the test strips should have changed color to indicate the chlorine sanitizing solution was at a level of 100 | F 812 | F 812 - Food Procurement, Store/Prepare/Serve-Sanitary<br><br>This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law.<br><br>1) Inspection and repair of the dish washer by Ecolab servicing technician was completed on 2/9/23. Evidence of the repair report was obtained.<br><br>All Maintenance repair requests submitted for non-working equipment.<br><br>All expired foods have been disposed and all open foods have been sealed, labeled and/or dated.<br><br>2) All residents have the potential to be affected.<br><br>3) To prevent this from recurring, the Dietary Manager and dietary staff were re-educated by the Regional Clinical Director on 2/9/23 in relation to the maintenance of the chemical sanitizing solution of the dish machine at the correct concentration according to manufacturer's recommendations., dish washing practices, 3 compartment sink washing | |

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| F 812 | Continued From page 7<br>ppm. Since he could not determine there was an acceptable concentration of chlorine in the sanitizing solution, the Dietary Manager told the dietary assistants using the dish machine to stop washing dishes until the sanitizing solution could be fixed. At that time, the facility's consultant Registered Dietitian (RD) and Corporate Vice President (VP) of Operations joined the Dietary Manager near the dish washing station. The consultant RD reported she had checked the dish machine's sanitizing solution with a test strip during the previous week. The RD stated the chlorine in the sanitizing solution was at the correct concentration when she conducted the test.<br><br>On 2/8/23 at 1:32 PM, the Corporate VP of Operations reported a servicing technician for the facility's dish machine had been called and was expected to arrive shortly to correct the problem with the sanitizing solution for the dish machine.<br><br>An interview was conducted on 2/8/23 at 2:45 PM with the servicing technician for the dish machine in the presence of the facility's Maintenance Director. During the interview, the technician reported the hose running from the container of chlorine sanitizing solution to the dish machine had slid out of the solution so none was going into the machine. Once that was corrected, he tested the concentration of the sanitizing solution and reported the concentration of chlorine actually tested high (about 300 ppm) so he adjusted it to the manufacturer's recommendation of 100 ppm of chlorine. When asked, the technician reported he did not notice how far out of the sanitizing solution the hose was when he first checked it. He could not provide an estimate of how long the sanitizing solution was not going into the | F 812 | and prevention of cross contamination during dish washing, implementation of dishware sanitation and storage standards.<br><br>Any dietary staff that cannot be reached within the initial reeducation time frame of 24 hours will not take an assignment until they have received this reeducation by the Dietary Manager/ designee.<br><br>The Dietary Manager and dietary staff were re-educated on 2/10/23 by the Registered Dietician in relation to disposal of expired food items, sealing, labeling and/or dating open food items in the storage area or Refrigerator.<br><br>The Dietary Manager will conduct audits to ensure that maintenance of the chemical sanitizing solution of the dish machine at the correct concentration according to manufacturer's recommendations, dishwashing practices, three compartment sink washing and prevention of cross contamination during washing, and implementation of dishware sanitation and storage standards. The audits will be conducted 3 x per day x 8 weeks, then weekly for 4 weeks. These audits will be conducted on all shifts. Any opportunities identified will be corrected.<br><br>4) Effective 3/9/ 2023, Dietary Manager will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring | |

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| F 812 | Continued From page 8<br>machine. The service technician recommended chlorine test strips be used at least daily to ensure the chlorine sanitizing solution was kept at an appropriate level of 100 ppm of chlorine. . When asked, the technician stated he typically came to the facility once a month to check the dish machine (and sanitizing solution) but it had been two months since he had last done so.<br><br>A follow-up interview was conducted on 2/8/23 at 3:00 PM with the Dietary Manager. During the interview, the Dietary Manager reported he was certain he himself had checked the dish machine's sanitizing solution with a test strip on Monday (2/6/23) and it checked out to be okay at that time. He reiterated the chlorine sanitizing solution for the dish machine should have a concentration of 100 ppm.<br><br>2. Accompanied by the facility's Dietary Manager, a continuous observation was conducted on 2/8/23 from 1:10 PM to 1:20 PM of the facility's dish washing process using a low temperature dish machine. Dietary Assistant #1 (DA #1) was observed to be the sole staff member working at the dishwasher. While wearing a pair of gloves, DA #1 was observed as he rinsed dirty dishes with a spray of water on the left side of the dish machine, slid the dish rack containing dirty dishes into the dish machine, and activated the machine. The DA did not change gloves or perform hand hygiene. When the dish machine was finished with the wash and rinse cycles, DA #1 moved to the right side of the dish machine. While there, he unloaded and stacked the cleaned plates and bowls from the dish rack. He then returned to the dirty side of the dish machine to begin the process over again. When the Dietary Manager was asked what his thoughts were about DA #1 | F 812 | or modification of this plan monthly x 3 months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. | |

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working on both the dirty and clean dishes without performing hand hygiene in-between, he stated that shouldn't be done. The Dietary Manager was observed as he called another DA (DA #2) over to work on the clean side of the dish machine while DA #1 worked on the dirty side. When asked, DA #1 stated he had not been told in the past that he needed to wash his hands when going between the dirty and clean sides of the dish machine.

The observation of the dish machine station continued as DA #1 was assigned to work exclusively on the dirty (left) side of the dish machine while DA #2 worked on the clean side of the dish machine. On 2/8/23 at 1:15 PM, DA #2 was observed as he pulled dome lids (used to cover plates) and divided plates from the clean rack of the dish machine after having been washed. He used a white cloth to dry the remaining water off the inside and outside of each dome lid and both sides of the divided plates before stacking them on a nearby rack.

An interview was conducted with the Dietary Manager on 2/8/23 at 1:15 PM. During this interview, the Dietary Manager was asked what his thoughts were regarding the practice of using a cloth to dry the dome lids and plates. The manager stated he was not sure. By this time, the facility's consultant RD had joined the Dietary Manager in the kitchen. The consultant RD was also asked what she thought about the practice of using a cloth to dry the dome lids and plates. The RD stated, "They have to be air dried."

3-a. Accompanied by the facility's Dietary Manager on 2/6/23 at 10:25 AM, an initial tour of the Dietary Department was conducted beginning

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| F 812 | Continued From page 10 | F 812 | | |

on 2/6/23 at 10:25 AM. The observations included the Department's dry storage area with the following concerns identified:
-- 2-16 ounce containers of parmesan cheese (one full and the other partially used) were stored in the dry storage area. The label on the parmesan cheese containers read, "Keep refrigerated." Upon inquiry, the Dietary Manager reported he would need to discard the parmesan cheese.
--A 50-pound (#) bag of pinto beans with approximately ½ remaining was labeled with a "best by" date of 12/16/22. The Dietary Manager reported the beans were beyond the best by date and needed to be discarded.
--An unlabeled, plastic zippered bag containing approximately 2-3 cups of an off-white, powder-appearing dry product was stored on a shelf in the dry storage area. The bag was not labeled with the product name or date the original container had been opened. Upon inquiry, the Dietary Manager reported the bag contained grits. He reported the bag containing the grits would need to be discarded.
--Two partially filled plastic bags of dried pasta were observed to be sealed but not labeled or dated as to when they had been opened.
--A plastic bag was observed to be stored inside the manufacturer's box labeled to contain 25 # of Instant Food Thickener. The plastic bag was left open with the thickener exposed to the air. Neither the bag nor the box were dated as to when the thickener had been opened. The Dietary Manager reported he would need to "go get a container" to store the thickener in an air-tight container.
--A 50 # bag of parboiled rice was observed to be opened with the top of the bag loosely folded over. The rice was not in a sealed container.

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| F 812 | Continued From page 11<br><br>Accompanied by the facility's Dietary Manager, an observation was conducted 2/6/23 at 10:35 AM of the walk-in cooler. Eight (8) 8-ounce cartons of whole milk were noted to have an expiration date of 2/4/23. The Dietary Manager reported the milk was expired and needed to be discarded.<br><br>3-b. Accompanied by the Maintenance Director and joined by the Corporate VP of Operations, a follow-up observation was conducted on 2/8/23 at 12:52 PM of the Dietary Department's food storage areas. The observations included the Department's dry storage area with the following concerns identified:<br>--A plastic bag was again observed to be stored inside the manufacturer's box labeled to contain 25 # of Instant Food Thickener. The plastic bag remained open with the thickener exposed to the air. Neither the bag nor the box were dated as to when the thickener had been opened.<br>--One (1) opened 46 oz. bottle of thickened iced tea was observed to be stored on a shelf in the dry storage room. The manufacturer labeling on the bottle read, "Refrigerate unused portion."<br><br>A follow-up interview was conducted on 2/8/23 at 3:00 PM with the Dietary Manager. During the interview, the Dietary Manager reported a Dietary staff in-service was scheduled with the consultant RD to re-educate staff on the survey concerns identified in the Dietary Department. | F 812 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written | F 867 | | 3/9/23 |

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| F 867 | Continued From page 12 | F 867 | | |

policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

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

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

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| F 867 | Continued From page 13<br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct | F 867 | | |

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| F 867 | Continued From page 14<br>distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).<br>Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after the annual recertification/complaint investigation survey of 10/28/21 with a citation that was recited on the current complaint survey of 2/9/23. This was evident for one recited deficiency in the area of | F 867 | F 867 - QAPI/QAA Improvement Activities<br><br>This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet | |

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| F 867 | Continued From page 15<br>Food Safety Requirements (F812). The continued failure of the facility during two federal surveys of record within the last 3 years show a pattern of the facility's inability to sustain an effective QAA Program.<br><br>The findings included:<br><br>This tag is cross referenced to:<br><br>F812: Based on observations, staff interviews and an interview with the service technician for the facility's dish machine, the facility failed to: 1) Maintain the chemical sanitizing solution of the dish machine at the correct concentration according to the manufacturer's recommendations during 1 of 1 observations of the dish washing process; 2) Failed to change gloves/wash hands between handling soiled and clean dishes to prevent cross-contamination of the clean dishes and failed to allow all clean dishware to air dry during 1 of 1 observations of the dish washing practices; and 3) Dispose of expired food items and seal, label, and/or date opened food items observed in food storage areas during 2 of 2 observations of the facility's food storage areas.<br><br>During the recertification / complaint investigation survey of 10/28/21, the facility was cited for failing to label leftovers and discard expired food from their walk- in refrigerator and failed to maintain the walk-in freezer in a safe operating condition. The kitchen's walk-in freezer had accumulated ice on the freezer floor. The facility failed to ensure the commercial dishwasher was maintaining wash and rinse temperatures according to the manufacturer's recommendations, failed to use clean lids to | F 867 | requirements established by federal and state law.<br><br>On 2/9/23 the corporate facility consultant in-serviced the QAPI Committee related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related F812.<br><br>On 2/22/23, the facility conducted quality assurance (QA) Committee meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) committee and review on-going compliance issues. The director of nursing (DON), minimum data set (MDS) nurse, dietary manager, maintenance director, medical records, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 2/22/23, the DON and Dietary Manager provided updates regarding plan of correction to the Medical Director.<br>All residents have the potential of being affected.<br><br>To prevent this from recurring, all citations in the previous year and current year will be reviewed and discussed at QAPI meeting monthly to ensure compliance with written plan of corrections for each citation, to measure it success and track performance to ensure improvements are realized and sustained.<br><br>To monitor and maintain ongoing | |

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| F 867 | Continued From page 16<br>cover food on the steam table, failed to ensure the glasses and cups stacked on the drying rack were clean and failed to ensure the sanitization solution strength used on the kitchen counter tops was within manufacturer's recommendation. The facility failed to keep the nourishment refrigerators clean, failed to label and discard food from 2 of 2 nourishment refrigerator/freezers and failed to maintain one of two nourishment refrigerator/ freezer (Station # 2) in safe temperature zone. The nourishment refrigerator temperature was above 40 degrees and the freezer must keep frozen foods frozen solid reviewed for food storage.<br><br>An interview was conducted on 2/9/23 at 3:00 PM with the facility's Interim Administrator. During the interview, the Interim Administrator reported she was fairly new to the facility. She confirmed her responsibilities included taking the lead for the facility's QAA committee. She stated her first participation in the facility's QAA program took place in January 2023. The Administrator reported since coming to the facility, she and the QAA team have identified several concerns within the Dietary Department and the kitchen was being monitored by the new consultant Registered Dietitian (RD) as part of the QAA program. When asked, the Administrator reported the previously identified concerns in the kitchen were not the same as those identified by the current survey process. The Interim Administrator stated when concerns were identified, she requested the department complete a QAPI action plan. The QAA committee would revisit the issue, monitor the outcomes, and revise the action plan as needed. | F 867 | compliance,<br>As of 2/22/23, after the corporate facility consultant in-serviced the QAPI Committee, the facility QAPI Committee will continue to identify other areas of quality concern through the quality improvement (QI) review process, for example: review of rounds tools and review of regional facility consultant recommendations.<br><br>The QAPI committee will meet at a minimum of monthly and the QAPI committee will meet a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns to ensure improvements are realized and sustained.<br><br>The Administrator or designee will review tracking forms utilized for QAPI, monthly to ensure compliance. The results of the reviews will be discussed at the monthly QAPI meeting.<br><br>Corrective action has been taken for the identified concerns and repeat deficiencies. | |