STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345416	A. BUILDING ______ B. WING ______	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERMUDA VILLAGE RETIREMENT CENTER	**142 BERMUDA VILLAGE DRIVE BERMUDA RUN, NC 27006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation was conducted 12/12/23 through 12/15/23. This facility was found in compliance with the requirments CFR 483.73, Emergency Preparedness. Event ID GELP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 12/12/23 through 12/15/23. Event ID: GELP11. The following intakes were investigated: NC00203602 and NC00203410. Six (6) of 6 complaint allegations did not result in a deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		1/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/12/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550 Continued From page 1

residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, family, and staff interviews the facility failed to treat a resident in a dignified manner by not removing a clothing protector after the lunch meal and before rolling the resident down the hallway to her room (Resident #17) and failed to ensure a catheter bag had a privacy cover (Resident #7) for 2 of 2 residents reviewed for dignity (Resident #17 and Resident #7). The reasonable person concept was applied as a reasonable person would not want to be rolled down the hallway with a clothing protector on and would not want a catheter bag visible to other residents and visitors.

The findings included:

1. Resident #17 was admitted to the facility on 06/10/21.

F 550

- ADON placed Privacy cover on resident #7 immediately
Director of nursing performed audit on all residents with catheters on 12/15/23 to ensure all residents with catheters had privacy covers and all non- compliance was addressed immediately

Resident # 17 clothing protector was removed immediately and involved staff educated.
Director of nursing monitored following meals served in dining room for compliance and all noncompliance was addressed immediately

Director of Nursing (DON) in serviced all team members on January 11th 2024 regarding Resident Rights and the

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F 550	Continued From page 2 Review of the significant change Minimum Data Set (MDS) assessment dated 10/17/23 revealed Resident #17 was severely cognitively impaired and was dependent for eating and personal hygiene. An observation of Resident #17 was made on 12/12/23 at 12:38 PM in the dining room. Resident #17 was observed to have a clothing protector in place and was assisted with her meal by the staff. When the staff were done assisting Resident #17 with her meal, Nurse Aide (NA) #1 was observed to push Resident #17 out of the dining room down the hallway to her room with her clothing protector in place. The clothing protector was not visibly soiled with food. NA #1 was interviewed on 12/12/23 at 12:47 PM who stated that he worked at the facility through an agency. He stated that they asked each resident if they wanted a clothing protector and they put one on the residents who were not able to tell them, to keep their clothes from getting dirty. NA #1 stated that if the clothing protector was soiled with food that he would take it off before leaving the dining room. He stated that he had taken Resident #17 back to her and laid her down and had taken off her clothing protector at that time. An observation of Resident #17 was made on 12/12/23 at 12:53 PM. Resident #17 was resting in her bed and her clothing protector had been removed. An interview with Resident #17's family was conducted on 12/14/23 at 12:35 PM. The family member stated that he visited the facility each day from 10:00 AM to 5:00 PM and always	F 550	necessity of upholding the dignity of the residents. DON reviewed the importance of residents as it pertains to dignity and the importance of removing clothing protectors from residents prior to leaving the dining area and the importance of all catheters having privacy covers. All new staff will receive education on residents rights (diginity) during new hire orientation Director of nursing or designee will ensure compliance by conducting weekly audits x 3 week to ensure residents are having clothing protectors removed in dining area. All adverse findings will be addressed immediately. This deficiency will be monitored in monthly QAPI to ensure resident rights and dignity are being upheld	

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F 550	Continued From page 3	F 550		

assisted Resident #17 with her meals. He stated the only day he had missed since her admission was Monday (12/12/23). The family member stated that the facility started using the cloth clothing protectors a couple of weeks ago and he liked them because it kept her clothes from getting soiled but stated "they definitely need to remove it" before taking her down the hallway. The family member further stated that Resident #17 used to her own her own business and was a very professional woman and would not want to be in the hallway with a clothing protector on.

The Director of Nursing (DON) was interviewed on 12/15/23 at 12:25 PM who stated that the facility had switched from disposable clothing protectors to cloth ones a couple of weeks ago. She stated that if the resident wanted one, they would put one on them and the other residents would get one to protect their clothes. The DON stated that the clothing protectors should be removed after the meal and before being pushed out of the dining room and down the hallway.

2. Resident #7 was readmitted to the facility on 10/20/23 with diagnoses that included retention of urine and neurogenic bladder.

Review of a quarterly Minimum Data Set (MDS) assessment dated 10/20/23 revealed Resident #7 was severely cognitively impaired and had an indwelling catheter.

Review of a care plan dated 11/28/23 read in part, Resident #7 has an alteration in bladder elimination with indwelling suprapubic catheter related to neurogenic bladder and chronic urinary retention. The interventions included: cover

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F 550	Continued From page 4 drainage bag when up to promote privacy. An observation of Resident #7 was made on 12/12/23 at 11:56 AM. Resident #7 was in his wheelchair in the dining room, his catheter bag was noted to be hanging from the bottom of his wheelchair and did not have privacy cover. The tubing and collection bag were noted to have clear yellow fluid in it. Nurse #1 was interviewed on 12/12/23 at 3:46 PM who confirmed that she was caring for Resident #7 and stated that all catheter bags should have a privacy cover on them. The Assistant Director of Nursing (ADON) and the Director of Nursing (DON) were interviewed on 12/15/23 at 12:30 PM. The ADON stated that she had replaced Resident #7's privacy bag on 12/12/23 directly after dinner when she noticed that he did not have one. She stated that he had multiple privacy covers in his room that could have been used. The DON stated all catheter bags should have a privacy cover.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other	F 561		1/12/24

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F 561	Continued From page 5 applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, and staff interviews the facility failed to honor a resident's wish to get out of bed and get her hair done for 1 of 3 residents reviewed for choices (Resident #5). The findings included: Resident #5 was admitted to the facility on 01/25/22 with diagnoses that included: dementia, cognitive communication deficit, and adult failure to thrive. Review of the quarterly Minimum Data Set (MDS) assessment dated 12/02/23 revealed that Resident #5 was moderately cognitively impaired and dependent for transfers from bed to chair and chair to bed. No behaviors or rejection of care were noted during the observation period. An observation and interview were conducted	F 561	Director of nursing immediately spoke with resident #5 and staff members involved. Resident was offered to get up but declined. Stated that she just wanted to get her hair done. All other interviewable residents were asked if they had request that were not being honored. No other issues were identified Resident placed on list for beautician to see resident at next available time. Staff member was immediately educated on resident rights The Director of Nursing (DON) or designee in-serviced nursing staff on 1/11/24 regarding Resident Rights and the importance of maintaining the resident's right to self-determination. All new staff will receive education on residents rights (self determination) during	

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F 561	Continued From page 6	F 561		

with Resident #5 on 12/12/23 at 10:48 AM. Resident #5 was resting in bed dressed in a gown, her hair was flat with some white flaky substances noted to her scalp and stated, "I am supposed to get my hair done." The resident further stated "When the staff come in, they say, hi how are you, and I say I am good. I am ready to get up and get dressed." The resident continued to explain the staff leave and never return. The resident said, "I am very disappointed because they come in and say how are you doing and then walk right out when I say I am waiting for someone to help me." Resident #5 stated she "keeps asking them and I always say please and thank you," but they won't get me up so I can get my hair done. There was a wheelchair noted to be sitting in Resident #5's bathroom.

An interview was conducted with the Beautician on 12/12/23 at 12:37 PM who stated if Resident #5 was up and wanted to get her done she would certainly be able to do her hair and confirmed that she had done her hair before in the facility's salon.

An observation and interview were conducted with Resident #5 on 12/12/23 at 3:58 PM. Resident #5 remained in bed dressed in a yellow zip up robe, her hair was flat with some white flaky substances noted to her scalp. Resident #5 stated "that African American girl dressed in the grey suit [Nursing Assistant (NA) #2], would not get me up when I asked." She further stated she "told her I did not want to wear something that was going to go over my head because I was going to get my hair curled." Resident #5 stated that the same staff member kept going to/from her closet with things that she did not want to wear because they all went over her head.

new hire orientation

The DON or designee will interview 10 residents weekly for three weeks to ensure resident rights are being honored.

All non-compliance will be addressed immediately

This deficiency will be monitored in monthly QAPI to ensure resident rights are being upheld

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F 561	Continued From page 7 Resident #5 stated she finally asked her, "If you are not going to help me, can I call someone else because you are not listening to me, please do not put anything over my head." NA #2 was interviewed on 12/13/23 at 12:22 PM who confirmed she took care of Resident #5 on 12/12/23. NA #2 confirmed Resident #5 wanted to get up yesterday to get her hair done so, "I tried to get her up, but she did not want anything to go over her head." NA #2 stated she had put a robe on Resident #5 that did not go over her head. NA #2 stated she did not even get the lift pad under Resident #5 because she "zoned out" when NA #2 was questioned what "zoned out" meant she said, "Maybe she had a fear of falling?" but could not explain why Resident #5 was not gotten up to get her hair done. NA #2 stated Resident #5 usually transferred with the lift and had no issues and alerted the staff to when she wanted to get out of bed. When NA #2 was again asked why she did not get Resident #5 out of bed on 12/12/23 she could not state a reason. The Assistant Director of Nursing (ADON) and Director of Nursing (DON) were interviewed on 12/15/23 at 12:19 PM. Both stated that they had not seen Resident #5 out of bed since they started working at the facility in June 2023 and October 2023. The ADON stated she had tried to obtain weight using the lift on Resident #5 and it has been very difficult. The DON stated typically if the resident wanted to get their hair done and they could not get out of bed they would arrange for the beautician to come to their room. However, if the resident requested to be up to get her hair done then she would expect the resident to be up as long as they could safely be up.	F 561		

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F 690	Continued From page 8	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (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. §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. This REQUIREMENT is not met as evidenced by:	F 690		1/12/24

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F 690	Continued From page 9 Based on observations, record review, resident, staff, and Medical Director interviews the facility failed to maintain urinary catheter tubing to allow for gravity flow of the urine for 2 of 2 residents reviewed with catheters (Resident #7 and Resident #18). The finding included: 1. Resident #7 was readmitted to the facility on 10/20/23 with diagnoses that included retention of urine and neurogenic bladder. Review of a quarterly Minimum Data Set (MDS) assessment dated 10/20/23 revealed Resident #7 was severely cognitively impaired and had an indwelling catheter. Review of a physician order dated 10/20/23 read; provide catheter care to suprapubic catheter every shift. Review of a care plan dated 11/28/23 read in part, Resident #7 has an alteration in bladder elimination with indwelling suprapubic catheter related to neurogenic bladder and chronic urinary retention. The interventions included: keep tubing free of kinks. An observation of Resident #7 was made on 12/12/23 at 11:56 AM. Resident #7 was in his wheelchair in the dining room, his catheter bag was noted to be hanging from the bottom of his wheelchair. The catheter tubing was noted to be down the inside right leg of his pants. The catheter tubing was then noted to come out of the pant leg then ran directly up over the side of a soft boot that was on his foot. The boot came up to the lower mid-calf of Resident #7 which	F 690	The catheter bags for resident #7 & #18 were immediately placed correctly. All residents with catheters was audited on 12/13/23 to make sure catheters were placed correctly to allow proper drainage. Any urinary catheter tubing not allowing for gravity flow of urine was corrected immediately. The DON or designee in-serviced nursing staff on 1/11/24 regarding the proper placement of catheter bags and tubing, to ensure catheter tubing allowed for the urine to flow to gravity. All new staff will be trained on proper placement of catheter tubing during orientation. Education added to agency education binder Director of nursing or designee will ensure compliance by conducting routine monitoring and weekly audits of all residents with catherers 1 x week times 3 weeks. All adverse findings will be addressed immediately This deficiency will be monitored in monthly QAPI to ensure resident dignity is being upheld	

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F 690	Continued From page 10	F 690		

obstructed the flow of urine. The tubing was noted to have clear yellow fluid in it.

Nurse #1 was interviewed on 12/12/23 at 3:46 PM who confirmed that she was caring for Resident #7 and stated that all catheter tubing should be positioned where it was not pulling and should be below the level of bladder and not obstructed for the flow of urine. Nurse #1 stated, "We do not want the residents getting urinary tract infections."

The Director of Nursing (DON) was interviewed on 12/15/23 at 12:30 PM. The DON stated that the tubing should be fed down Resident #7's pant leg but not over the boot where it obstructed the flow of urine.

The Medical Director (MD) was interviewed on 12/15/23 at 1:41 PM who stated that Resident #7's catheter tubing placement "was less than ideal" and stated that all urinary catheter tubing should allow for gravity flow of urine to ensure proper drainage.

2. Resident #18 was admitted to the facility on 05/23/23 with diagnoses that included neuromuscular dysfunction of the bladder and retention of urine.

Review of a quarterly Minimum Data Set (MDS) assessment dated 11/05/23 revealed that Resident #18 was cognitively intact and had an indwelling catheter. No rejection of care was noted.

An observation of Resident #18 was made on 12/12/23 at 3:23 PM. Nurse Aide (NA) #3 was observed to be rolling Resident #18 down the hallway and into her room and shut the door.

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An observation and interview were conducted with Resident #18 on 12/12/23 at 3:33 PM. Resident #18 was sitting in her recliner with her bed that was approximately two feet away. Resident #18's catheter tubing was stretched from Resident #18 in the recliner to the bed where the drainage bag hung, the tubing was pulled very tight across the space between the bed and recliner. Resident #18 stated that the catheter tubing was pulling and "the tubing should go down not horizontal and as you can see it is horizontal."

Nurse #1 was asked to assist Resident #18 on 12/12/23 at 3:41 PM. Nurse #1 entered Resident #18's room and stated that tubing should not be stretched between the bed and recliner and should be hanging below the bladder to allow for proper drainage. Nurse #1 was observed to move the recliner and bed closer together to allow for the urinary catheter tubing to allow for gravity flow of the urine and stated, "I don't want you getting a urinary tract infection."

NA #3 was interviewed on 12/12/23 at 4:06 PM who confirmed that she had pushed Resident #18 to her room after an activity and assisted her to the recliner in her room. She stated that she wanted to hang the catheter bag on her recliner but Resident #18 did not want it to hang on her recliner, so she hung it on the bed and confirmed that she saw that it was stretched tight between the bed and recliner but "wasn't sure what to do." NA #3 stated that the generally did not work on this unit and was not familiar with Resident #18 and could not recall taking of care of her before. She stated she was just floating on the unit and was helping out wherever she was needed.

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F 690	Continued From page 12 The Director of Nursing (DON) was interviewed on 12/15/23 at 12:30 PM who stated that NA #3 should have moved the recliner closer to the bed, so the catheter tubing was not pulling and not stretched between the bed and recliner. She also stated that NA #3 should have ensured that the catheter tubing was hanging appropriately to allow for proper drainage. The Medical Director (MD) was interviewed on 12/15/23 at 1:41 PM who stated that Resident #18's catheter tubing placement "was less than ideal" and stated that all urinary catheter tubing should allow for gravity flow of urine to ensure proper drainage.	F 690		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732		1/12/24

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F 732	Continued From page 13 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to post nursing staffing hours on the weekends. The facility posted staffing hours Monday through Friday but not on the weekends for 3 of 3 months reviewed. The findings included: An interview was conducted with the Staffing Coordinator on 12/13/23 at 2:35 PM who stated that she was responsible for posting the nursing staffing hours each day. She stated that she would fill out the sheets each day and post them outside of the Director of Nursing (DON)'s office. She stated that she only worked Monday through Friday and she would fill out the sheets for the weekend on Monday when she came into work. The DON was interviewed on 12/15/23 at 11:21 AM who stated that the Staffing Coordinator was	F 732	Director of Nursing (DON) in serviced the scheduler and weekend supervisor on 12/15/23 to include the importance of posting staffing hours on the weekend. Staff sheets were posted correctly Scheduler will leave forms for weekend supervisor to post in real-time. Adjustments will be done as needed All new team members will be in serviced upon hire of policy on posting staffing hours seven days a week Director of nursing or designee will ensure compliance by conducting weekly audits x 3 weeks. All adverse findings will be addressed immediately. This deficiency will be monitored in	

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F 732	Continued From page 14 responsible for completing the nursing staffing hours and posting them in the appropriate place. The DON stated that the Staffing Coordinator should be filling out the weekend sheets on Friday and having the weekend staff update them as needed and post them. The Administrator was interviewed on 12/15/23 at 4:30 PM and indicated that the nursing staffing hours should be posted daily including the weekends.	F 732	monthly QAPI to ensure staffing hours are being posted 7 days a week	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Consultant Pharmacist, and Medical Director interviews the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 6 (Resident #2) residents reviewed for unnecessary medications. The findings included:	F 740	Administrator and Director of Nursing met with Medical director on 12/19/23 to discuss the need for behavioral health service and the process to obtain behavioral health services for qualified residents. Resident # 2 was discussed with Medical director of designee and seen no urgent need for behavioral health services on 12/19/23	1/12/24

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F 740

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1. Resident #2 was readmitted to the facility on 03/15/20 with diagnoses that included major depressive disorder and anxiety.

Review of the quarterly Minimum Data Set (MDS) assessment dated 11/26/23 revealed that Resident #2 was severely cognitively impaired, had no signs of delirium, and had no behaviors or rejection of care during the assessment reference period. The MDS further indicated that Resident #2 received an antipsychotic, antianxiety, and antidepressant medication during the assessment reference period.

Review of a care plan dated 12/05/23 read; Resident #26 is on psychotropics. The goal read, Resident #26 will be free of depressive behaviors and adverse effects of medication through the review period. The interventions included: administer psych medications as ordered, allow residents to express feelings with an accepting manner, monitor and report any changes in behavior, monitor and document all behaviors related to depression such as episodes of tearfulness, withdrawn from friends/family, and keep resident free from pain.

Review of a summary of physician orders dated December 2023 revealed that Resident #2 was prescribed the following medications: Alprazolam (antianxiety) 0.5 milligrams (mg) by mouth at bedtime for anxiety and insomnia, Seroquel (antipsychotic) 12.5 mg by mouth three times a day for dementia with behaviors, and Duloxetine (antidepressant) 30 mg by mouth every day for depression.

The Consultant Pharmacist was interviewed on 12/13/23 at 11:46 AM who stated that she

F 740

The facility contracted with a behavioral health professional on 1/12/24. The new behavioral health professional will evaluate resident #2 by 1/19/24.

Staff inservices started on 1/15/24. Behavioral health providers will offer staff inservices during the week 1/22/24-1/26/24.
All new staff will receive education on behavioral health services during new hire orientation

Facility residents with appropriate diagnoses that are referred to the behavioral health professional by their primary care physician will be seen. DON or designee will monitor residents that are referred to ensure compliance. Any residents with needs will be discussed during weekly risk meeting.

Future residents with appropriate diagnoses that are referred to behavioral health will be evaluated by the behavioral health professional as needed.

Will monitor for compliance during monthly QA

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F 740	Continued From page 16	F 740		

reviewed Resident #2's medical record and medications each month. She stated that Resident #2 had been on Seroquel for over a year, and she had requested a gradual dose reduction in May 2023 and the Medical Director (MD) declined the change. She then stated she had again recommended a gradual dose reduction last month and the MD stated he would address it on his next regulatory visit. The Consultant Pharmacist stated she reviewed any behavior documentation that was in Resident #2's chart and she had noted reports in June 2023 of the resident seeing things that were not there and reports that she (the resident) had recently had a baby. When the Consultant Pharmacist was asked if she reviewed the mental health provider notes she replied, "to my knowledge they do not have psych services here" and the MD manages all the psychotropic medications.

An observation and interview were conducted with Resident #2 on 12/14/23 at 11:31 AM. Resident #2 was sitting in her wheelchair in her room. Resident #2 appeared somber and had somewhat of a flat affect. She stated that she had suffered from depression for a long time and, "I am not as happy as other people. I miss my family, I am 93 years old, and a lot of people have gone by. I have 2 children and that is all I have left." Resident #2 could not recall if she took anything for her depression but stated, "I think I would like to talk to someone about my depression." "I think I am ready to pass away because I am 93 years old and if I make it to June, I will be 94." Resident #2 was asked how she felt about living such a long life and she stated, "it does not matter to me if I am here or in heaven when I turn 94."

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F 740	Continued From page 17 The Social Worker was interviewed on 12/14/23 at 2:21 PM who stated that the MD managed all the psychotropic medications and if there was a question about mental health the MD would talk to the resident. She added that if they noticed a change in mood the MD would handle it. The Social Worker confirmed that the facility did not have a mental health provider that visited the facility and agreed that Resident #2 would benefit from talking to someone about her depression. The Director of Nursing (DON) was interviewed on 12/15/23 at 12:36 PM and confirmed that the facility did not have a mental health provider because "we are a small facility." She stated the MD specialized in geriatrics and if he felt like a resident needed to see a mental health provider, he would write a referral. If the staff noted a change in a resident, we would let the MD know and he would decide if they needed anything more. The MD was interviewed on 12/15/23 at 1:41 PM who stated that he felt comfortable with the current procedures at the facility. He stated he was trained in geriatrics and was aware how to prescribe psychotropic medications. "If I have a concern with a patient I can discuss with my colleagues." The MD stated he would not be opposed to a mental health provider coming to the facility and agreed that Resident #2 would benefit from talking to someone about her depression.	F 740		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from	F 757		1/12/24

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F 757	Continued From page 18 unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, and Medical Director interviews the facility failed to prevent the wrong pain medication from being given to the wrong resident (Resident #41) for 1 of 6 residents reviewed for unnecessary medications. The findings included: Resident #41 was admitted to the facility on 05/29/23 and was discharged on 06/30/23 with diagnoses that included status post cerebral vascular accident, arthritis, and osteoarthritis. Review of the admission Minimum Data Set (MDS) assessment dated 06/02/23 revealed that Resident #41 was cognitively intact. The MDS	F 757	Med error that occurred on resident #41 was immediately reported to MD and POA. Resident was monitored for any adverse effects per MD order. Med error report filed and proper processes were followed During the week of 12/17/23- 12/23/23- Daily med pass audits were completed to monitor for med errors. No med areas noted The Director of Nursing (DON) or designee completed an in-service on 1/11/24 regarding proper medication administration. Specifically, the DON or designee in-serviced on giving the correct	

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F 757	Continued From page 19 further revealed that Resident #41 had no pain during the assessment reference period and received no opioid medications. Review of a medication error report dated 06/08/23 at 11:30 AM read, "this nurse approached the resident with medication and verified her name. The resident shook her head yes. This nurse proceeded to give her the medication. The head of therapy came to this nurse afterwards and said that this was not the patient. Vital signs were taken and will continue to be taken as per protocol." Director of Nursing (DON) and medical provider informed at 11:40 AM and family notified at 12:45 PM. The form was filled out by Nurse #2. Nurse #2 was interviewed on 12/14/23 at 9:58 AM via phone. Nurse #2 confirmed that she no longer worked at the facility but did work at the facility on 06/08/23. Nurse #2 confirmed that she recalled the medication error but could not recall what medication was administered to the wrong resident and could not recall which resident the medication was intended for. Nurse #2 stated Resident #41 "was new to me at the time" but I verified her name, and she shook her yes and I administered the medication. Nurse #2 further explained she called a name that was not Resident #41's and she shook her head yes. "I was notified within minutes that was not the correct patient." Nurse #2 stated that therapist was in the room at the time, but she could not recall which therapist. Nurse #2 stated she monitored Resident #41's vital signs over the rest of the day and she had no change in her condition except she was a little sleepy. Nurse #2 could not recall if she completed the medication error report or which provider was notified of the	F 757	medication to the correct resident and in the correct setting. All new staff will be educated duing orientation process The DON or designee will routinely monitor and audit medication pass weekly x 3 weeks for compliance Pharmacy consultant performs audits and audits are discussed in monthly QAPI All non-compliance will be addressed immediately. This defiency will be reviewed by the QAPI team monthly	

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F 757	Continued From page 20 event. Resident #41's family member was interviewed on 12/14/23 at 10:31 via phone. The family member stated that she recalled the medication error that occurred to Resident #41 on 06/08/23. She stated that the former Administrator had told her that Resident #41 had received a Percocet (pain medication) 10 milligrams (mg) that was intended for Resident #83 both residents were in the therapy gym. Resident #83 was admitted to the facility on 06/06/23 and was discharged on 06/20/23. Review of a physician order dated 06/06/23 for Resident #83 read: Oxycodone-Acetaminophen (Percocet) 10 mg by mouth five times a day for pain. An interview with the Occupational Therapy Assistant (COTA) was conducted via phone on 12/14/23 at 10:23 AM. The COTA recalled that Resident #41 was in the therapy gym waiting to start her therapy session. She further stated Nurse #2 came in and asked Resident #41 her name and date of birth and Resident #41 responded with the information. Then Nurse #2 asked Resident #41 if she was [stated Resident #83's name] and Resident #41 shook her head yes and Nurse #2 gave her Resident #83's medication. The COTA could not recall which medication it was and stated she informed Nurse #2 that was not the correct patient. After Nurse #2 was notified of the error the COTA stated she also reported it to the Director of Nursing (DON). The former DON was interviewed via phone on 12/13/23 at 3:09 PM who confirmed that she was	F 757		

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F 757	Continued From page 21	F 757		

the DON at the time of the medication error on 06/08/23. She stated that she "vaguely "remembered the error. The DON stated that Nurse #2 made the error, but she could not recall which medication was administered to Resident #41 or who the medication was intended for. She stated that the error was reported, and the medial provider notified. The former DON could also not recall if there were any orders given at the time the medical provider was notified or not. She also recalled that the family was notified of the error.

The former Administrator was interviewed via phone on 12/14/23 at 4:57 PM and confirmed that she worked at the facility at the time of the medication error on 06/08/23. The Administrator stated the error "sounded familiar" but she could not recall specific information about it, she added, "I think the DON handled that."

The current DON was interviewed on 12/15/23 at 12:12 PM. She stated that each record had a picture of the resident, and the staff should be looking at the pictures to identify the correct resident and should not be medicating residents in common areas to avoid errors like this one.

The Medical Director (MD) was interviewed on 12/15/23 at 1:41 PM. The MD stated he was notified of the medication error involving Resident #41 on 06/08/23 and the staff were instructed to closely monitor the resident over the next 24 hours. The MD stated that there was no serious harm to the resident. The MD added with a Percocet the patient may become drowsy and fall asleep but that is "essentially the worst that could happen" and it did not drastically change her rehab course.

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F 812 SS=F	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, record review and staff interviews, the facility failed to remove expired nutritional supplements from 1 of 1 satellite kitchen that were available for use and did not date or monitor the use of frozen bread prior to meal service. The practices had the potential to affect food served to residents. The findings included: 1. During an observation of a satellite kitchen on 12/12/23 at 10:31 AM, 2 bottles of nutritional supplement with a use by date of 05/08/23 were observed in the storage cabinet and were available for use.	F 812	All expired nutritional supplements were discarded immediately. All bread products that was expired was discarded immediately. Facility put new policy in place that all bread products will be dated when removed from the freezer then used or discarded within 5 days of removal from the freezer. The food service manager or designee audited all food storage areas for expired nutritional supplements on 1/11/24. No expired supplements were found.	1/12/24

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F 812	Continued From page 23	F 812		

An interview with the Dietary Manager on 12/12/23 at 10:39 AM revealed he had a designated culinary team that prepared and served out of the satellite kitchen. The Dietary manager reported the nutritional shake was not something his department was responsible for and did not know why or how it had ended up in the storage cabinet. The Dietary Manager reported although the nutritional shakes were not something that should be stored in the satellite kitchen, his team should have caught them and removed them when they were going through the pantry on their daily rounds.

During an interview with the Director of Nursing on 12/12/23 at 10:44 AM, she reported it was her understanding that the kitchen staff were responsible for checking the pantry in the satellite kitchen and for removing items that were expired. She verified that nutritional shakes were not typically stored in the satellite kitchen, but that there should not be any items that were expired stored in the satellite kitchen's pantry.

During an interview with the Administrator on 12/15/23 at 3:44 PM, he reported typically the nutritional shakes were to be kept at the nurse's station. The Administrator also reported despite where the nutritional shakes were found, they should have been checked and removed on their expiration date.

2. During an observation of meal service on 12/12/23 at 12:37 PM an observation was made of 4 bags of hamburger buns with a use by date of 10/03/23. There was no other opened or received by dates observed on the bags. The hamburger buns were being prepared to be served to the residents and service was stopped

The food service manager or designee in-serviced dietary staff on 1/11/24 regarding the procedure to monitor all food items and supplements for the correct expiration dates.
All new employees will be educated on the proper bread policy and how to observe for expired food during orientation

The food service manager or designee will audit weekly times 3 weeks to ensure compliance.
All non-compliance will be corrected immediately.

This defiency will be reviewed during monthly QPAI meeting

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F 812	Continued From page 24 by the surveyor. During an interview with the Dietary Manager on 12/12/23 at 12:40 PM, he reported the facility received the hamburger buns frozen and he had pulled them out earlier that morning, defrosted them and insisted they were ok for use. The Dietary Manager reported all the bread the facility utilized was delivered frozen. During a follow-up interview with the Dietary Manager on 12/13/23 at 11:57 AM, he reported the facility had utilized frozen bread delivery since he arrived at the facility, and they did not use fresh bread delivery. He stated it was his understanding that frozen bread was good beyond the use by date if it was received prior to the use by date and had not been defrosted. The Dietary Manager indicated he would begin dating the frozen bread when it arrived and then would date the bread when he pulled it for use. During an interview with the Administrator on 12/15/23 at 3:44 PM, he reported he expected the dietary staff to follow the policies and procedures of the facility and ensured the frozen bread was properly labeled and dated at the time it arrived and when it was pulled for use.	F 812		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		1/12/24

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F 842	Continued From page 25 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 26 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to maintain an accurate medical record when they recorded weights for 2 of 3 residents reviewed for nutrition. (Resident #33 and Resident #19). The findings included: 1. Resident #19 was admitted to the facility on 05/08/23. A review of Resident #19's quarterly Minimum Data Set assessment dated 09/16/23 revealed resident to be cognitively intact. A review of Resident #19's recorded weights revealed the following recorded weights in Resident #19's medical record on the corresponding dates:	F 842	Residents #33 & #19 were immediately re- weighed and their weights recorded into the EMR. The Director of Nursing (DON) or designee performed an audit on all resident weights on 1/10/24. The weights were recorded into each residents EMR. Any weight discrepancies were reweighed DON or designee will routinely monitor weights for discrepancies and any weight changes will be addressed immediately The Director of Nursing (DON) or designee in-serviced nursing staff on 1/11/24 regarding how to obtain accurate resident weights and how to properly record into the EMR.	

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F 842	Continued From page 27 163.7 pounds (lbs) on 10/02/23 0.0lbs on 10/05/23 0.0lbs on 10/06/23 0.0lbs on 10/09/23 0.0lbs on 10/10/23 168lbs on 11/02/23 The above weights were coded as being entered by Nurse #2. During an interview with Nurse #2 on 12/15/23 at 1:21 PM, she reported Resident #19 had never weighed 0.0 pounds while admitted to the facility. She stated she did not know why it was entered like that but stated if her initials were beside the weight, then she would have been the one to record it in the system. She stated having a recorded weight for Resident #19 as 0.0lbs was not an accurate reflection of Resident #19's weight at the time. During an interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) on 12/15/23 at 3:28 PM, they reported they were aware of an issue their electronic health record had at some point where, if a nurse input a weight into the medication administration record it would input it into the electronic medical record as 0.0lbs. They reported they thought they had fixed the issue but stated they must have overlooked Resident #19's recorded 0.0lbs. weights. They reported the inaccurate weights should have been struck out as they were not accurate reflections of Resident #19's weights at the time. The ADON and DON reported resident weights should be entered into the resident medical records accurately. During an interview with the Administrator on	F 842	All new staff will receive education on how to obtain accurate resident weights and record in EMR during orientation Education on obtaining weights added to agency binder Registered dietician performs bi-weekly audits and abnormal weights are addressed with MD, and DON. These audits are addressed in QAPI This deficiency will be monitored in monthly QAPI to ensure resident weights are being obtained and charted correctly	

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12/15/23 at 3:57 PM revealed he expected recorded weights in the medical record should be accurate reflections of the resident's weights and reported having 4 recorded weights for Resident #19 as 0.0lbs were not accurate reflections of his weight at the time.

2. Resident #33 was readmitted to the facility on 12/07/23.

A review of Resident #33's most recent Minimum Data Set assessment revealed her to be cognitively intact.

A review of Resident #33's recorded weights in her medical record revealed the following recorded weights on the corresponding dates:

94.3 lbs. on 07/26/23
92.4 lbs. on 07/27/23
155.4 lbs. on 07/31/23
92.6 lbs. on 08/02/23

The above weights were coded as being entered by Nurse #2.

During an interview with Nurse #2 on 12/15/23 at 1:08PM, she reported the hall nurse aides typically take the resident weights and they would write them on paper and give them to her and she, in turn, would input the weights into the electronic medical record. She reported she typically compared previous weights and if a weight looked significantly different from previous weights, she would go and reweigh the resident herself to ensure it was accurate before she recorded the weight the nurse aide provided. Nurse #2 reported the weight on 07/31/23 of 155.4 lbs. was inaccurate and she felt as though

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F 842	Continued From page 29 the weight included the weight of Resident #33's wheelchair. She stated when residents were weighed in their wheelchair, she had to deduct the weight of the wheelchair from the measured weight and then record the difference. She reported she must have overlooked or missed the inaccurate weight. Nurse #2 verified that Resident #33 had never weighed 155.4 lbs. while she had been admitted to the facility. An interview with Resident #33 on 12/13/23 at 9:57 AM, she reported she had never weighed 155 pounds in her life. An interview with the ADON and the DON on 12/15/23 at 3:37 PM revealed Resident #33's baseline weight typically remained in the mid 90's. They reported the recorded weight in Resident #33's health record appeared to be inaccurate and most likely included the weight of her wheelchair. The ADON reported when staff weighed residents, they were to adjust the weight to not include the weight of the wheelchair to ensure it was accurate. The DON and ADON both reported 155 pounds was not an accurate reflection of Resident #33's weight. During an interview with the Administrator on 12/15/23 at 3:57 PM revealed he expected recorded weights in the medical record should be accurate reflections of the resident's weights and reported having a recorded weight for Resident #33 as 155 pounds was not an accurate reflection of her weight at the time.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and	F 867		1/12/24

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

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

§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

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F 867	Continued From page 31 systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.	F 867		

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F 867	Continued From page 32 §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint survey conducted on 06/09/22. This failure was for 3	F 867	Administrator held a meeting with the Interdisciplinary Team on 1/9/2024 to reinforce the importance and necessity of a thorough QAPI review and process. DON or designee will conduct weekly audits x 3 weeks for repeat tags	

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F 867

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deficiency's that were originally cited in the area of Resident Rights (F550), Nursing Services (732), and Dietary Services (F812) that were subsequently recited on the current recertification and complaint investigation survey of 12/15/23. The repeat deficiencies during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program.

The findings included:

This tag is cross referred to:

F550: Based on observation, record review, family, and staff interviews the facility failed to treat a resident in a dignified manner by not removing her clothing protector after her lunch meal and before rolling Resident #17 down the hallway to her room for 1 of 2 residents reviewed for dignity (Resident #17). The reasonable person concept was applied as a reasonable person would not want to be rolled down the hallway with a clothing protector on.

During the recertification and complaint survey of 06/09/22 the facility failed to provide a dignified dining experience for the residents on the 200, 400, and 600 halls by providing them with foam cups and plastic bowls during four observed meals.

F732: Based on record review and staff interviews the facility failed to post nursing staffing hours on the weekends. The facility posted staffing hours Monday through Friday but not on the weekends for 3 of 3 months reviewed.

During the recertification and complaint survey of

F 867

Food service manger or designee will conduct weekly audits x 3 weeks for repeat tag

Next QAPI meeting set to discuss the repeat tags and to implement a process to remediate these deficiencies.

Director of nursing or designee will ensure compliance by conducting routine monitoring and audits. All adverse findings will be addressed immediately.

All new dietary and nursing staff will be educated during new hire orientation.

The repeat tags will be monitored monthly to ensure ongoing compliance

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F 867	Continued From page 34 06/09/22 the facility failed to ensure daily nurse staffing information was maintained for a minimum of 18 months. The facility maintained daily nurse staffing sheets for 6 out of 18 months. F812: Based on observations, record review and staff interviews, the facility failed to remove expired nutritional supplements from 1 of 1 satellite kitchen that were available for use and did not date or monitor the use of frozen bread prior to meal service. The practices had the potential to affect food served to residents. During the recertification and complaint survey of 06/09/22 the facility failed to maintain sanitary conditions in the main kitchen, satellite kitchen, and food storage areas of the facility: by not ensuring food items and food service supplies were not stored on the floor; by not ensuring resealed food items were dated and labeled during storage; by not maintaining the food service equipment in clean and debris-free condition; by not ensuring pots/pans and other dishware were stacked clean and dry; by not ensuring staff were wearing hair coverings on their heads and chin guards for facial hair during food preparations; and by not preventing cross contamination of cleaned dishware when using the dishwashing machine. The Administrator was interviewed on 12/15/23 at 3:15 PM who stated the QA committee met quarterly and included all department managers, Medical Director, Consultant Pharmacist, and Registered Dietician. The QA committee followed an agenda that included discussing old business, talking about performance improvement plans that were in place and the progression of those, and then current business. Each department went	F 867		

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F 867	Continued From page 35 through their section of QA. The Administrator stated that when issues arose, they would discuss them in QA, assign them out, do a follow up and determine how the performance improvement plan was going and determined if it needed to continue or not. He also added that a main focus of QA was revolving around the full operation of the kitchen looking at food temps, kitchen sanitation, and other issues that came up during the QA meeting. The Administrator stated that the team would attack the areas that were identified on the current recertification survey just as they have the other issues to ensure that they were corrected and resolved.	F 867		