STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

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E 000	Initial Comments An unannounced Recertification Survey and complaint investigation were conducted on 8/9/21 through 8/12/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #DWWQ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation surveys were conducted from 8/9/21 through 8/12/21. Event ID# DWWQ11. [x] _2_ of the _69_ complaint allegations were substantiated but did not result in a deficiency. [x] _25_ of the _69_ complaint allegations were substantiated resulting in deficiencies. [x] _42_ of the _69_ complaint allegations were not substantiated.	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.	F 550		9/9/21

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

Electronically Signed | 09/02/2021

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F 550	Continued From page 1 §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 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, and staff interview, the facility failed to provide a dignified, homelike environment as evidenced by standing to feed a resident and leaving a resident only dressed in an undergarment during feeding for 1 of 8 residents reviewed (Resident #111). Findings included: Resident #111 was admitted to the facility on 6/22/21. Resident #111's care plan dated 6/22/2021	F 550	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing(DON) provided education for NA #5 on 8/9/2021,regarding sitting while feeding a resident and properly dressing or covering a resident to provide a dignified homelike environment. The DON observed Resident #111 on	

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F 550	Continued From page 2 documented assistance with activities of daily living (dependent for feeding). Resident #111's 5-day Minimum Data Set dated 6/27/21 documented the resident understood and was severely cognitively impaired. The resident was dependent for activities of daily living. On 8/11/21 at 8:45 am an observation was done of Resident #111 in his room during breakfast. NA #5 was present feeding the resident. NA #5 was standing to feed. The resident was only wearing an undergarment (no clothing). The bedsheet was underneath the resident and there was no blanket observed. NA #5 encouraged the resident to "at least drink" and continued to stand for the entire feeding. On 8/11/21 at 8:45 am an interview was conducted with NA #5. NA #5 stated she always stood to feed because she cannot reach the resident when she sat. When asked if the resident had clothes, the NA did not respond. On 8/11/21 14 11:40 am interview was conducted with the Administrator. She stated that staff were expected to sit when feeding residents and (agreed) residents should be covered or dressed (when only in an undergarment).	F 550	8/10/2021, while staff were feeding and the resident was properly covered and staff member was sitting while feeding the resident. The resident is cognitively impaired and does not recall if a staff member stood to feed or failed to cover or dress . Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents that need assistance with eating and dressing are at risk to be affected by staff failure to sit while assisting with meals and dressing resident to provide a dignified homelike environment. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The DON and Unit Managers completed education on 8/31/2021, for nursing staff regarding sitting while feeding a resident and properly dressing or covering a resident to provide a dignified homelike environment Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and Unit Managers will observe 10 residents that are dependent on staff for feeding and dressing, weekly for 4 weeks, then 20 residents monthly for 2	

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F 550	Continued From page 3	F 550	months. The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		9/9/21

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F 583	Continued From page 4 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide privacy during a bed bath having had the window shade open for 1 of 8 residents reviewed (Resident #111). Findings included: Resident #111 was admitted to the facility on 6/22/21. Resident #111's care plan dated 6/22/21 documented assistance needed with activities of daily living. Resident #111's 5-day Minimum Data Set dated 6/27/21 documented the resident understood and was severely cognitively impaired. The resident was dependent for activities of daily living. On 08/09/21 at 11:20 am an observation was done of Resident #111 in his room while he received a bed bath. NA #5 undressed the resident, and he was sitting on the side of the bed while the NA obtained soap and water from the bathroom. The resident stated he was cold while sitting on the bed. The resident's bed was on the window side of the room and the smoking patio/area was just outside the resident's window. The shade was open. Staff and residents could	F 583	Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing(DON)provided education for NA #5 on 8/9/2021, regarding providing privacy when providing care to residents, to include closing the window shades, privacy curtain, and door. The DON observed Resident #111 on 8/10/2021, while NA was providing care. The window shade was closed and privacy was provided. Resident #111 is cognitively impaired and did not recall if a staff member had left window shade open during care. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility resident that are dependent on staff to provide privacy during care are at risk for the alleged	

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F 583	Continued From page 5 be observed to enter, sit, and exit the patio in front of the resident's room window. The NA asked the resident to lie down and provided a bed bath next to the window. On 8/9/2021 at 11:22 an interview was conducted with NA #5. NA #5 was asked about the open shade and the NA stated, "because the resident's window had a screen, you could not see inside (from the outside) of the window." The NA asked the resident if he wanted the shade closed but he could not understand due to cognitive deficit. (Surveyor exited the resident's room and entered the smoking patio. The resident could be observed through his room window with open shade that he was undressed on his bed). The Surveyor returned to the resident's room and informed the NA what was observed. The NA was requested to close the shade (the NA made no attempt to close the shade until asked). On 8/11/2021 11:40 am interview was conducted with the Administrator. She stated that staff were expected to provide residents privacy while bathing (any type of exposure).	F 583	deficient practice of leaving window shade open during care. Address what measures will be put in place tor systemic changes made to ensure that the deficient practice does not recur: The DON and Unit Managers completed education on 8/31/2021, for nursing staff regarding providing privacy when providing care to residents, to include closing window shade, privacy curtain and door. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and Unit Managers will observe 10 residents that are dependent on staff for providing privacy during care weekly for 4 weeks, the 20 residents monthly for 2 months. The DON will review audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the committee.	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)	F 604		9/9/21

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F 604	Continued From page 6 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, resident, and family interview, the facility failed to provide a restraint-free environment for 1 of 1 resident observed (Resident #138). Findings included:	F 604	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing(DON) completed	

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F 604	Continued From page 7 Resident #138 was admitted to the facility on 5/18/08 with the diagnosis of mood disorder. Resident #138 ' s quarterly Minimum Data Set dated 7/8/21 documented she understood/understands and had clear speech. The resident ' s mental status was not evaluated and was coded having memory deficit. The active diagnosis was non-Alzheimer ' s dementia. Restraint was coded no. Resident #138 ' s care plan dated 6/28/21 documented a history of falls related to loss of balance trying to run from staff, improper foot-wear, non-compliance with safety recommendations, and weakness. On 08/9/21 at 11:40 am an observation was done of Resident #138 sitting in her wheelchair in her room. The resident resided on the locked unit/Hall 200. A family member was visiting. A black, web lap belt with black enclosure was around Resident #138 ' s waist and attached to the wheelchair. It appeared that the belt was restraining the resident from being able to stand up. The resident tried to open the lap belt closure/buckle and was unable. On 8/9/21 at 11:40 am an interview was conducted with Resident #138 ' s family member in the resident ' s room. The family member stated that the resident has had a history of falling and not cooperating. The facility placed the belt on the resident ' s wheelchair, it held her in and prevented her from falling. The nursing assistant usually placed the resident in her wheelchair and placed the belt in the morning. The family member directed the resident to open the lap belt closure/buckle and the resident was unable.	F 604	a restraint assessment on 8/9/2021, for Resident #138 to determine the need for a seat belt. The belt was attached to the chair was part of a cushion, to hold the cushion in place. The belt was removed from the chair. The resident was assessed and a seat belt was not needed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents that are using restraints are at risk for failure to provide a restraint free environment. The DON and Unit Managers completed an audit on 8/31/2021 of current residents to identify residents with restraints. There were no other residents identified with a restraint. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The DON and Unit Managers completed education on 8/31/2021 for nursing staff, regarding the use of restraints. Education included to assure adaptive equipment is properly secured and not used as a restraint. Staff are not to attach a restraint until the resident has been assessed and a physician order obtained to include type of restraint, diagnosis, release and ongoing monitoring and assessment. Indicate how the facility plans to monitor	

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F 604	Continued From page 8 On 8/9/21 at 11:40 am an interview was conducted with Resident #138. The resident was able to follow directions, but speech was mumbled. The resident attempted to open the lap belt closure/buckle attached to her wheelchair and stated, "you remove." On 8/9/21 at 1:10 pm an observation was done during lunch tray pass. Resident #138 was observed in her wheelchair with the lap belt in place. On 8/9/21 at 4:10 pm an observation was done of Resident #138 sitting in her wheelchair and self-propelling in the hall (Hall 200). The lap belt remained in place. On 8/10/21 at 10:45 am an observation was done of Resident #138 sitting in her wheelchair in her room. Nurse #8 entered the resident ' s room. The resident ' s wheelchair lap belt had been removed. On 8/10/21 at 10:45 am an interview was conducted with Nurse #8 who was assigned to Resident #138. She stated that there was no lap belt (agreed) that the belt was removed today because of the survey, and the resident has had a lap belt in the past. Nurse #8 stated that sometimes the nursing assistants (NA) used the belt on the wheelchair (resident has had a history of falling). On 8/11/21 at 9:00 am an observation of Resident #138 was done. The resident was in her wheelchair and there was no lap belt. On 8/11/2021 at 10:30 am interview was	F 604	its performance to make sure that solutions are sustained: The DON and Unit Managers will conduct random audits of 10 residents weekly x 4 weeks, then 20 residents monthly x 2 months, to identify and validate use of a restraint. The DON will review audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and audits will continue at the discretion of the QAPI committee.	

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F 604	Continued From page 9 conducted with Nurse #8. The nurse stated that the belt was present on Resident #138's wheelchair until today (yesterday), it was removed. The nurse stated she had not placed the lap belt. On 8/11/2021 at 11:50 am an interview was conducted with the Administrator. The Administrator stated the wheelchair belt was to hold the resident ' s pillow. After the resident attempted to remove the lap belt unsuccessfully, the Administrator stated (agreed) the lap belt was a restraint and would be removed. On 8/11/2021 at 1:20 pm an observation was done of Resident #138 while in her wheelchair self-propelling on the hall. There was no lap belt around the resident. The resident attempted to stand up from her wheelchair and staff could not redirect her. Staff remained/supervised the resident until the resident received her lunch tray and discontinued attempts to stand.	F 604		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff, resident and family interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 5 of 35 residents reviewed (Residents #138, #132, #75, and #100). Findings included: 1. Resident #138 was admitted to the facility on	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The MDS nurse completed a modified assessment on 8/30/2021 for Resident #138 to correct coding for sections B/ C/	9/9/21

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F 641	Continued From page 10 5/18/08 with the diagnosis of mood disorder. Resident #138 ' s quarterly Minimum Data Set dated 7/8/21 documented she understood/understands and had clear speech. The resident ' s mental status (BIMS) was not evaluated and was coded having memory deficit. The active diagnosis was non-Alzheimer ' s dementia. Medication Section was coded received an antipsychotic for 7 days and "no" for antipsychotics received. Resident #138 ' s care plan dated 6/28/21 documented a memory deficit and potential for wandering. On 08/9/21 at 11:30 am an observation and concurrent interview was done of Resident #138. The resident was able to follow directions and, although speech was mumbled, it was audible and intelligible (able to understand). On 8/9/21 at 11:30 an interview was conducted with Resident #138 ' s family member in the resident ' s room. The family member stated that the resident was not always cooperative but was able to make her needs known and had mumbled speech that you could understand. On 8/12/21 at 1:30 an interview was conducted with the MDS Nurse. Resident #138 ' s quarterly MDS dated 7/8/21 was reviewed and Section Medication was coded "no" for anti-psychotic medication. The coordinator stated coding "no" was an error and would be corrected. On 8/12/21 at 1:35 pm an interview was conducted with the Speech Therapist (ST). Resident #138 ' s quarterly MDS dated 7/8/21	F 641	and N. The MDS nure completed a modified/significant correction MDS assessment on 9/1/2021, for resident#132 to correct coding to reflect a Level II PASSR. The MDS nurse completed a modified MDS assessment on 8/12/2021 for Resident #75 to correct coding to reflect a Level II PASSR. The MDS nurse completed a modified/significant correction MDS assessment on 8/19/2021 for Resident #100 to correct coding to reflect a Level II PASSR. The MDS nurse completed a modified MDS assessment on 8/12/2021 for Resident #172 to reflect accurate pressure ulcer coding under Section M of the MDS. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents have the potential to be affected. The MDS nurses completed an audit on 9/1/2021 to validate that residents with Level II PASSRs, antipsychotic medications, pressure injury were coded accurately. There were a total of 46 MDS assessments identified as coded	

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F 641	Continued From page 11 was reviewed and the BIMS was not evaluated for the resident who had clear speech and understood/understands. The ST stated that not completing the BIMS was an error and would be corrected. On 8/11/2021 at 11:50 am an interview was conducted with the Administrator. The Administrator stated that staff were required to accurately code the MDS. 2. Resident #132 had been admitted on 10/12/2020. Her diagnoses included schizophrenia and major depressive disorder. Review of Resident #132's demographic information indicated she had a Level II Preadmission Screening and Resident Review (PASRR, a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines) determination upon admission to the facility. The admission MDS assessment dated 10/22/2020 did not indicate Resident #132 was currently considered by the state Level II PASRR process to have serious mental illness. Facility documentation was reviewed and indicated Resident #132 had a Level II PASRR determination start date of 10/7/2020 with no expiration date. An interview was conducted on 8/12/2021 at 11:21 AM with the MDS nurse. She stated the MDS nurses were responsible to code the PASRR determination on the assessments. She	F 641	inaccurately for sections of PASSR, antipsychotic medication, pressure injury and cognition. MDS assessments identified coded inaccurately will be corrected/modified with an ARD no later than 9/9/2021. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Corporate MDS/Reimbursement Specialist provided education on 8/30/2021 for the MDS nurses and DON regarding accurate coding of Sections B,C,M,N and PASSR coding, according to the RAI manual. The MDS nurses will code MDS assessments accurately using documentation provided in the residents medical record. The MDS nurse will review the accuracy prior to submission to the state. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Director of Nursing will audit 10 MDS assessments weekly x 4 weeks, then 3 residents per week x 2 months to validate that sections B,C,M, N and PASSR coding are accurate. The DON will review the audits monthly to identify patterns/trends and will adjust the	

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F 641	Continued From page 12 further explained that Resident #132 had a Level II PASRR determination, and this should have been coded on the comprehensive assessment. An interview was conducted on 8/12/2021 at 12:30 PM with the Director of Nursing (DON). She stated the MDS assessments should be coded accurately. 3. Resident #75 had been admitted on 8/6/2020. His diagnoses included schizophrenia and anxiety. Review of Resident #75's demographic information indicated he had a Level II Preadmission Screening and Resident Review (PASRR, a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines) determination upon admission to the facility. The annual MDS assessment dated 7/1/2021 did not indicate Resident #75 was currently considered by the state Level II PASRR process to have serious mental illness. Facility documentation was reviewed and indicated Resident #75 had a limited Level II PASRR determination with an end date of 8/2/2021. An interview was conducted on 8/12/2021 at 11:21 AM with the MDS nurse. She stated the MDS nurses were responsible to code the PASRR determination on the assessments. She further explained that Resident #75 had a Level II PASRR determination, and this should have been coded on the comprehensive assessment. An interview was conducted on 8/12/2021 at 12:30 PM with the Director of Nursing (DON).	F 641	plan as necessary to maintain compliance. The DON will review the plan during monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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She stated the MDS assessments should be coded accurately.

4. Resident #100 had been admitted on 10/26/2017. Her diagnoses included major depressive disorder, anxiety, and unspecified psychotic disorder.

Review of Resident #100's demographic information indicated she had a Level II Preadmission Screening and Resident Review (PASRR, a resident identified as having a serious mental illness or intellectual debility as defined by state and federal guidelines) determination upon admission to the facility.

The annual MDS assessment dated 10/2/2020 did not indicate Resident #100 was currently considered by the state Level II PASRR process to have serious mental illness.

Facility documentation was reviewed and indicated Resident #100 had a Level II PASRR determination start date of 4/5/2019 with no expiration date.

An interview was conducted on 8/12/2021 at 11:21 AM with the MDS nurse. She stated the MDS nurses were responsible to code the PASRR determination on the assessments. She further explained that Resident #100 had a Level II PASRR determination, and this should have been coded on the comprehensive assessment. An interview was conducted on 8/12/2021 at 12:30 PM with the Director of Nursing (DON). She stated the MDS assessments should be coded accurately.

5. Resident #172 had been admitted on

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6/14/2021. Her diagnoses included dementia, hypertension, and chronic kidney disease.

A skin/wound note dated 6/16/2021 indicated Resident #172's skin was warm, dry, and clean. No open areas were noted.

Review of Resident #172's admission MDS assessment dated 6/20/2021 did not indicate any pressure ulcers present.
A Weekly Skin Assessment note dated 6/29/2021 at 10:43 AM noted Resident #172 had excoriation in clusters. All surrounding skin intact. Treatment changed. Will continue to monitor. No complaint of pain upon assessment. Physician aware.

A physician order dated 6/29/2021 to cleanse sacrum with normal saline, apply xeroform and a dry dressing daily (to sacrum).

Review of the June and July 2021 Treatment Administration Record (TAR) revealed a treatment to Resident #172's sacrum had been initiated on 6/30/2021. Treatment for the sacral area continued through 7/29/2021.
Resident #172 had been discharged return anticipated on 7/1/2021. No pressure ulcers were noted as present.

Resident #172 had been readmitted on 7/2/2021.

Nursing documentation dated 7/3/21 at 7:35 PM noted no new skin abnormalities. Resident had a previously identified skin areas/abnormalities which included open areas on the sacrum/coccyx. Air mattress in use and wound treatment in progress.

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F 641	Continued From page 15 A quarterly MDS assessment dated 7/15/2021 indicated one Stage IV pressure ulcer was present upon admission. On 8/09/21 at 2:30 PM an interview with Nurse #9 who regularly cared for Resident #172 was conducted. She stated Resident #172 had a wound on her bottom which was new since admission. She explained the treatment nurse cared for the wound. On 8/10/21 at 9:16 AM an interview with the wound nurse was conducted. She stated the wound was considered a "trauma" wound due to Resident #172 scooting around bed her bed and in her chair. She explained the wound had developed since admission, had never been worse than a Stage III and was now healed. On 8/12/21 at 11:21 AM an interview was conducted with the MDS Nurse. After reviewing the wound log, the nurse stated Resident #172 had acquired a trauma wound while a resident and it should not have been coded on the MDS assessment as a Stage IV pressure wound present upon admission. An interview was conducted on 8/12/2021 at 12:30 PM with the Director of Nursing (DON). She stated the MDS assessments should be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		9/9/21

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resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff

Address how corrective action will be

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F 656	Continued From page 17 interview, the facility failed to develop a care plan in the areas of smoking (Resident #96) and CPAP (continuous positive airway pressure) management (Resident #111) for 2 of 35 residents reviewed. Findings included: 1. Resident #96 was admitted to the facility on 5/14/2021 with the diagnosis of liver disease. Resident #96 ' s quarterly Minimum Data Set (MDS) dated 6/29/21 documented an intact cognition. The active diagnosis was hepatic failure without coma. A review of Resident #96 ' s care plan dated 5/14/2021 revealed he was not care planned for smoking. Resident #96 ' s smoking evaluation dated 5/14/21 documented the resident did not smoke (mark no for 14-day quarantine and was not evaluated for safety and independence after quarantine). On 08/10/21 at 9:15 am an observation was done of Resident #96 in his room. The resident was sitting on the side of his bed and a flat, open box of loose cigarettes (approximately 12) were observed. On 8/10/21 at 9:15 am an interview was conducted with Resident #96. The resident stated that he smoked, stored his smoking material in his room, and had a lighter. The resident stated that he was an independent smoker. On 8/11/2021 at 2:05 pm Resident #96 was observed to independently smoke in the	F 656	accomplished for those residents found to have been affected by the deficient practice: The MDS nurses initiated a care plan for smoking on 8/31/2021 for Resident #96. The MDS nurse initiated a care plan for use of CPAP on 8/31/2021 for Resident #111. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents that smoke and use a CPAP have the risk to be affected. The MDS nurses completed an audit on 8/31/2021 to identify residents that smoke and use a CPAP/BIPAP, and validated that the residents identified has a care plan. There were 4 residents identified without a care plan to reflect smoking or use of BIPAP/CPAP and all corrections were made. Care plan was initiated when identified. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Corporate MDS/Reimbursement Specialist Nurse provided education on 8/30/2021 for the MDS nurses regarding initiation of comprehensive care plans to	

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F 656	Continued From page 18 designated smoking area (fenced patio). On 8/11/2021 at 11:50 am an interview was conducted with the Administrator. The Administrator stated (agreed) that staff were required to develop the resident care plan to meet resident needs. 2. Resident #111 was admitted to the facility on 6/22/21 with the diagnosis of sleep apnea. Resident #111 ' s care plan dated 6/22/2021 documented respiratory disease with difficulty breathing related to sleep apnea and to be monitored. Care plan did not include a plan for CPAP management. Resident #111 ' s 5-day MDS dated 6/27/21 documented the resident understood and was severely cognitively impaired. The active diagnosis was sleep apnea. On 08/09/21 at 11:45 am an observation was done of Resident #111 lying in his bed. On the nightstand was a CPAP machine and a nasal CPAP mask was sitting on the wheelchair seat. On 8/11/2021 at 11:50 am an interview was conducted with the Administrator. The Administrator stated (agreed) that staff were required to develop the resident care plan to meet resident needs.	F 656	reflect the residents care and needs. The MDS nurses will initiate and update comprehensive care plans within 21 days of admission, or when a change is identified that requires a care plan to be initiated or updated. The Interdisciplinary team will review and update the care plans at least quarterly to reflect the current care and needs of the resident. Indicate how the facility plans to monitor its performance to make sure solutions are sustained: The Director of Nursing and/or Assistant Director of Nursing will audit 10 residents charts a week x 4 weeks then 3 a week x 2 months to validate that comprehensive care plans are initiated and reflect the residents current needs and care. The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		9/9/21

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F 684	Continued From page 19 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interviews and record review, the facility failed to provide mobile cardiac telemetry (MCT), failed to return monitor and communicate with the cardiologist for 1 of 1 (Resident #98) sampled resident reviewed for specialty services. Findings included: Resident was admitted to the facility on 1/20/20. The diagnoses included diabetes, depression, hemiplegia, hypertension, chronic sleep apnea, arterial and left ischemic stroke and transient ischemic attack. The quarterly Minimum Data Set (MDS) dated 4/9/21, coded Resident #98 as having cognition impairments and required total assistance with activities of daily living. Care plan dated 8/3/21, documented the problem as Resident #98 had hypertension and the goal included Resident #98 would remain free from sign/symptoms and complications related of hypertension. The approaches included Resident #98 would avoid taking the blood pressure reading after physical activity or emotion distress. Educate the resident/family/caregiver about: the importance of maintaining a normal weight for height, the value of regular, exercise, limiting salt intake, the adverse effects of tobacco and alcohol, the importance of medication and diet compliance. Give anti-hypertensive medications	F 684	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #98 has a follow up appointment with the cardiologist on 10/11/2021. Discussion with cardiology and appointment was not emergent. Address hos the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents that have appointments with consulting physicians are at risk. The DON and Unit Managers completed an audit on 8/31/2021 of current facility residents who had appointments from July 1, 2021 through August 27,2021 to validate that the follow up appointments and/or tests were completed and followed up. There were no other concerns with appointments or follow ups noted as a result of this audit.	

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F 684	Continued From page 20 as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (Tachycardia) and effectiveness. Monitor for and document any edema. Notify MD. Report significant changes to the MD. Monitor/document/report PRN any signs/symptoms of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing. Physician orders dated 9/28/20 documented resident had a heart monitor on middle of chest for 30 days, and notes resident seen at outpatient clinic. We recommend an elective echo with contrast with atrial septal defect(ASD) (order) and a 3 D mobile cardiac telemetry(MCT) monitor that must be returned to clinic for evaluate for atrial fibrillation. Additional order dated 9/29/20 documented FYI resident have on heart monitor on middle of upper chest for 30 days. Interview on 8/11/21 at 2:24 PM, the Nurse #7 stated she had seen Resident #98 ' s monitor in the medication room, and it was mailed back to the clinic. Nurse #7 confirmed there was no documentation of the monitor being sent back to clinic. Nurse#7 stated she had not seen any reports or recommendation from clinic reports until 8/11/21. Nurse #7 stated nursing should have documented receipt of monitor, return of monitor and receipt of the consultation report for physician review. Review of the physician progress note dated 9/30/2020, read in part" Resident #98 was seen for appointment with cardiology/ neurology for his follow-up appt for stroke assessment. Resident #98 was evaluated on 2/17/2020 for stroke. I	F 684	Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The DON and Unit Managers completed education for licensed nurses and scheduler on 9/1/2021 regarding process for scheduling appointments and follow through regarding future appointments and/or labs and tests. The Scheduler will obtain physician notes/recommendations from the office and provide to the licensed nurse upon return to the facility. The Scheduler will schedule any future appointments and will notify the nursing staff. A schedule of appointments will be given to the DON and Unit Managers daily, alerting them of appointments for the day. The Unit Manager will follow up at the end of the day to assure that the resident attended the appointment and will validate scheduling of future appointments and/or labs/tests. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and/or ADON will audit 5 residents weekly x 4 weeks then 10 residents monthly x 2 months to validate that residents with appointments attended the appointment and future appointments and labs/tests were scheduled and/or completed.	

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F 684	Continued From page 21 ordered an MCT monitor which listed as being placed but there is no result in the system and the MCT monitor return. Telephone interview on 8/10/21 at 3:08 PM, daughter stated Resident #98 was ordered to wear a heart monitor for a week back in February 2020, however the facility lost the monitor. She added Resident #98 returned to cardiology appointment September 2020 for a follow-up and the heart monitor was ordered again and it was expected that the monitor be returned to the cardiologist so they could determine the cause of his condition and/or prescribe proper medication. The facility did not return the monitor to cardiologist, therefore there were no results for them to review. Review of the virtual neurology report dated 11/27/20, read in part: Resident #98 had a history of strokes with known risk factors of hypertension, lipidemia and lipoprotein. Resident #98 was referred to the EP (electrophysiologist) service for an implanted loop monitor but the note from September 2020 suggested that the 21- day event monitoring was ordered but it does not appear that it was done. Interview on 8/11/21 at 1:22 PM, the Unit Manger #2(UM) stated she was responsible for ensuring that all consult reports were returned and submitted to the physician for review. UM#2 acknowledged the cardiology report was not in Resident #98 ' s record until 8/11/21. UM#2 further stated she was unable to confirm the monitor was in place and it had been returned to the cardiologist. Interview on 8/11/21 at 3:22 PM, the Scheduler	F 684	The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	

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#2, stated she called the spoke with the family in September 2020 to inform them of the appointment. Scheduler #2 she had not received the physician reports from Resident #98 ' s visits until 8/11/21. She further confirmed she did not re-schedule resident for a follow-up appointment after the completion of Resident #98 ' s monitoring.

Interview on 8/11/21 at 3:51 PM, the Director of Nursing stated they did not have any of the neurological or cardiological reports on record for Resident #98 until 8/11/21. The DON further stated there was no documentation the monitor was in place or the monitor was returned, therefore there were no results available.

Interview on 8/11/21 on 3:56 PM, the Administrator stated the expectation was for the director of nursing, unit managers and nursing staff to follow-up on obtaining consultation and physician reports and ensure the information was available for physician review and placed in the resident ' s record. The Administrator acknowledge there was no system in place ensure receipt of monitors, documentation of recommended physician information, follow-up procedures to obtain reports, monitoring residents on monitoring devices and return of monitors.

Interview on 8/12/21 at 10:30 AM, the Physician #2 stated the expectation would be for nursing to follow the physician orders. The heart monitor should have been in place and the monitor should have returned to the cardiologist for review. The residents should keep appointments to ensure medical interventions and/or follow-up care were done.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, the facility failed to provide a safe environment as evidenced by a resident had smoking material in his possession unsecured (room) and was not evaluated for safe/independent smoking for 1 of 2 residents observed for smoking (Resident #96). Findings included: A review of the facility smoking policy dated July 2017 documented "resident privileges are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, lighter, matches, and other smoking articles in their possession." (room) Resident #96 was admitted to the facility on 5/14/2021 with the diagnosis of liver disease. Resident #96 ' s quarterly Minimum Data Set dated 5/14/21 documented an intact cognition. The active diagnoses were hepatic failure without coma. A review of Resident #96 ' s care plan dated 5/14/2021 revealed smoking was not care planned.	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The licensed nurse completed a smoking assessment on Resident #96 on 8/10/2021. resident #96 is assessed as a unsupervised smoker. The Social Worker reviewed the smoking contract with Resident #96 on 9/1/2021, which includes that smoking items are kept at the nurses station. Resident #96 was given a copy of the signed smoking contract. The Social worker removed the smoking items from Resident #96 room and secured them at the nurses station on 9/2/2021. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	9/9/21

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	345434	A. BUILDING _____ B. WING _____	C 08/12/2021

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F 689	Continued From page 24 Resident #96 ' s smoking evaluation dated 5/14/21 documented the resident did not smoke (was not evaluated for safety). A review of the facility smoking roster revealed Resident #96's name was listed for Halls 100 and 200 scheduled as an independent smoker. On 08/10/21 at 9:15 am an observation was done of Resident #96 in his room. The resident was sitting on the side of his bed and a flat, open box of loose cigarettes (approximately 12) were observed. On 8/10/21 at 9:15 am an interview was conducted with Resident #96. The resident stated that he smoked, stored his smoking material in his room, and had a lighter. The resident stated that he was an independent smoker. On 8/10/21 at 11:25 am an interview was conducted with Nurse #7. The nurse stated that Resident #96 had cigarettes and a lighter in his room. The resident rolled his own cigarettes. Nurse #7 stated she was not aware of the facility policy that residents were not permitted to have smoking material in their room. The nurse also stated most residents who were independent smokers had smoking material in their room. On 8/11/2021 at 11:50 am an interview was conducted with the Administrator. The Administrator stated that some residents had cigarettes and lighter in rooms, facility policy indicated that staff would manage, and residents would ask for smoking materials when their assigned time to smoke. The Administrator	F 689	Current facility residents that smoke have the potential to be affected. The DON and Unit Managers identified residents that are assessed to smoke, and validated on 9/3/2021 that smoking items were not kept in the residents room. Smoking items were found in residents rooms and removed and kept at nurses stations. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The licensed nurse will assess residents upon admission, quarterly and significant change to determine if the resident smokes and if the resident is an independent or supervised smoker. The social worker will provide the resident with the smoking contract which explains the rules regarding storage of smoking items. The resident will sign the contract. The contract will be kept in the resident's medical record and a copy will be provided to the resident. The DON, Unit Managers, and Social Worker completed education for facility staff on 9/3/2021, regarding the facility smoking policy, assessment of residents that smoke and the smoking contract, that includes smoking items to be stored at the nurses station. The Social Worker and Administrator met	

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F 689	Continued From page 25 stated she knew it was a problem that was tough to control and attempted to manage (no smoking materials in resident rooms). The Administrator stated (agreed) there was a hazard that other non-oriented residents could have access to smoking material and all residents need to be evaluated for smoking safety.	F 689	with residents that smoke on 9/1/2021, and provided each resident with the smoking contract and reviewed the contract and facility policy. Each resident signed the contract and the contract was placed in the residents medical record and a copy was given to the resident. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, Unit Managers and Social Worker will do random observation of 10 rooms of the residents that smoke weekly x 4 weeks then 20 monthly x 2 months to validate that smoking items are not stored in the residents rooms. The DON will review audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPY meeting and audits will continue at the discretion of the QAPI committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		9/9/21

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F 695	Continued From page 26 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview, the facility failed to clean continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP) facial and nasal mask for 2 of 3 residents observed (Residents #2 and 111). Findings included: The facility policy dated 3/2015 documented for CPAP/BiPAP "4. Wipe machine with warm, soapy water and rinse at least once a week and as needed ... 7. masks, nasal pillows, and tubing: clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow to air dry between uses. Machine cleaning wipe with warm soapy water and rinse at least once a week and as needed." 1. Resident #2 was admitted to the facility on 8/17/16 with the diagnosis of obstructive sleep apnea (not breathing). Resident #2 had a physician order dated 6/29/21 documented BiPAP setting 14/7 to be applied at bedtime. Resident #2 ' s annual Minimum Data Set (MDS) dated 7/8/21 documented a vision deficit and he was moderately cognitively impaired. The resident ' s activities of daily living required extensive assistance of 1 staff. The active diagnoses were chronic obstructive pulmonary disease and obstructive sleep apnea.	F 695	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The licensed nurse received an order on 8/24/2021 to clean the CPAP facial mask for Resident #2. The licensed nurse received and order on 8/30/2021 to clean the CPAP facial mask for Resident #111. The DON and Unit Managers completed education for the licensed nurses on 8/31/2021 regarding cleaning and storage of CPAP/BIPAP machine, mask, and tubing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current facility residents with orders for CPAP/BIPAP have the potential to be affected. On 8/30/2021, the DON and Unit Managers identified residents with orders for BIPAP and CPAP to validate that the machine, tubing and masks were cleaned and stored in a storage bag at residents bedside. All machines, tubing and masks	

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F 695	Continued From page 27 Resident #2 ' s care plan last updated on 8/6/21 documented respiratory disease goals and intervention. A review of Resident #2 ' s nursing notes from 8/1/2021 to 8/9/2021 had no documentation that the resident ' s BiPAP facial mask was cleaned. On 08/9/21 at 11:20 am an observation was done of Resident #2 sitting up in his bed. The resident ' s BiPAP mask was on the floor. The BiPAP mask was made of clear plastic and appeared dirty with cloudy/brown on the clear plastic. The BiPAP machine was still running and had brown smears and dust on the top. On 8/9/21 at 11:20 am an interview was conducted with Resident #2. Resident #2 stated that the staff does not wash his BiPAP mask each day. On 8/10/21 at 11:00 am an interview was conducted with Nurse #6 who was assigned to Resident #2. Nurse #6 stated that staff placed the CPAP (BiPAP) on the resident at bedtime. The resident took his CPAP off on his own in the morning and sometimes it wound up on the floor. Nurse #6 stated there was no order for CPAP mask cleaning or tubing date label. Nurse #6 stated she does not know who cleaned the CPAP mask or how often (policy), possibly the nursing assistant (NA). The mask was stored on the resident ' s nightstand (not in a bag or secured device). On 8/11/21 at 8:45 am an interview was conducted of NA #5 who was assigned to Resident #2. The NA stated she had not cleaned the CPAP mask or machine, that was nursing ' s	F 695	were cleaned and stored in a storage bag at bedside. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The DON and Unit Managers completed education for the licensed nurses on 8/31/2021 regarding cleaning and storage of CPAP/BIPAP machine, mask and tubing. Upon admission or when a resident receives an order for a CPAP or BIPAP, the order will include cleaning of machine, mask and tubing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON and/or Unit Managers will observe all residents with CPAP/BIPAP 3 x a week for 4 weeks then weekly for 2 months, to validate that CPAP/BIPAP machine, tubing, and mask are cleaned and stored in storage bag at bedside. The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and audits will	

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F 695	Continued From page 28 responsibility. On 8/10/2021 at 12:55 pm an observation was done of Resident #2 sitting up in his bed. The resident ' s CPAP mask was sitting on the nightstand, appeared to be less soiled, and was not stored to prevent falling on the floor. The CPAP machine remained in the same condition. On 8/11/2021 11:40 am interview was conducted with the Administrator. She stated that the resident ' s CPAP mask was expected to be cleaned each day and stored (enclosed). She also stated there was a policy for CPAP/BiPAP management. On 8/12/21 at 11:35 am an interview was conducted with Nurse #7. She stated that CPAP masks were required to be washed every morning with soap and water and dried. She also stated that CPAP management was usually documented on the medication administration sheet. 2. Resident #111 was admitted to the facility on 6/22/21 with the diagnosis of sleep apnea. Resident #111 ' s care plan dated 6/22/2021 documented respiratory disease with difficulty breathing related to sleep apnea and to be monitored. Care plan had no plan for CPAP management. Resident #111 ' s 5-day MDS dated 6/27/21 documented the resident understood and was severely cognitively impaired. Resident was dependent for activities of daily living. The active diagnosis was sleep apnea.	F 695	continue at the discretion of the QAPI committee.	

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F 695	Continued From page 29	F 695		

On 08/09/21 at 11:45 am an observation was done of Resident #111 lying in his bed. On the nightstand was a CPAP machine set up with no water in the reservoir. The nasal CPAP mask was on lying on the wheelchair seat and the tubing was lying on the floor (potential for the mask to fall on the floor).

On 8/9/21 at 11:45 am an interview was conducted with NA #5. She stated that "nursing assistants do not do anything with the CPAP, that was nursing ' s responsibility."

On 8/10/21 at 11:00 am an interview was conducted with Nurse #6. Nurse #6 stated that staff placed the CPAP on Resident #111 at bedtime and was removed in the morning. Nurse #6 stated there was no order for CPAP mask cleaning. Nurse #6 stated she does not know who cleaned the CPAP mask or how often (policy), possibly the nursing assistant (NA). The mask was stored on the resident ' s nightstand (not in a bag or secured device).

On 8/11/2021 at 8:45 am an observation was done of Resident #111 ' s room. The resident ' s nasal CPAP mask was sitting on the nightstand (not secured).

On 8/11/2021 11:40 am interview was conducted with the Administrator. She stated that the resident ' s CPAP (BiPAP) mask was expected to be cleaned each day and stored (enclosed). She also stated there was a policy for CPAP/BiPAP management.

On 8/12/21 at 11:35 am an interview was conducted with Nurse #7. She stated that CPAP masks were required to be washed every

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F 695	Continued From page 30 morning with soap and water and dried. She also stated that CPAP management was usually documented on the medication administration sheet.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to label food, discard expired food, and clean 2 of 2 nourishment refrigerators reviewed for food storage (400 hallway and 100 hallway nourishment refrigerators). Findings included: On 8/9/21 at 10:31 AM, an observation of the nourishment refrigerator on 400 hallway revealed	F 812	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Dietary manager cleaned the nourishment room refrigerators on 100 and 400 halls on 8/9/2021. The Housekeeping department defrosted	9/9/21

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F 812	Continued From page 31 1) a brown paper bag containing a 2 pounds plastic container, with "yogurt" printed on it. There was no label on the bag or container. 2) one 46 fluid ounces (fl oz.) tetra pack labeled "orange juice" with expiration date 7/10/21. 3) one opened 16 ounce (oz) can of energy drink, one opened 20 oz soda bottle, 3 opened 16 oz water bottles, one opened 16 oz bottle with reddish/orange drink in it. There was no label or date on them. An observation of the freezer revealed large accumulation of ice. The freezer contained a frozen 24 oz plastic soda bottle, a half peanut butter sandwich was frozen and a frozen 16 oz water bottle. These items were not labeled. During an interview on 8/9/21 at 10:35 AM, the Certified Dietary Manager (CDM) stated the nurses were responsible to label any food brought in by resident's family prior to be placed in the refrigerator. The nursing staff were not allowed to keep personal food in the nourishment refrigerator. The CDM indicated any dietary staff could notify the maintenance director to help with defrosting of the freezer. On 8/9/21 at 10:39 AM, an observation of the nourishment refrigerator on 100 hallway revealed a plastic bag containing homemade food on a plate. There was no label indicating resident's name or use by date on it. The food was wrapped by a cling wrap. The nourishment refrigerator also contained one 7 fl. oz plastic bottle "protein shake" with no label and a 4 oz. orange juice cup with no expiration date on it. The floor of the nourishment refrigerator had yellow stains on it. During an interview on 8/9/21 at 10:45 AM, the CDM stated the nourishment refrigerators were cleaned weekly by the dietary staff. He further	F 812	the 400 hall nourishment room freezer on 8/10/2021. The Administrator educated the Dietary manager and housekeeping manager on 8/13/2021 regarding cleaning and monitoring nourishment room refrigerators. The DON and/or Unit managers completed education for nursing staff on 9/1/2021 regarding dating and labeling food items that are placed in the nourishment room refrigerator. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All nourishment room refrigerators are at risk to be affected. On 8/9/2021, the dietary manager completed an audit of all nourishment refrigerators to validate that refrigerators/freezers were clean and all items inside were dated and labeled. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided by the Administrator, DON, Unit Managers and Dietary manager on 9/1/2021, to the dietary and nursing staff regarding cleaning of the nourishment room	

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F 812	Continued From page 32 stated staff personal food should not be placed in the nourishment refrigerator. All resident's food should be labeled and dated by nursing staff prior to placing them in the nourishment refrigerator. The CDM indicated individual orange juice cups should be labeled with a use by date by the dietary staff prior to be placed in the nourishment refrigerator. During an interview on 8/10/21 at 8:12 AM, the Maintenance Director stated he does not assist with defrosting the nourishment refrigerators. He indicated the housekeeping staff were responsible for defrosting the nourishment refrigerators. During an interview on 8/11/21 at 9:16 AM, the Housekeeping Manager (HM) stated the housekeeping staff defrosted the nourishment refrigerator once a month and as needed. HM further stated the dietary staff should notify the housekeeping staff when the nourishment refrigerators needed defrosting. HM indicated he was unsure when the refrigerator was defrosted. The HM indicated the dietary staff were responsible for cleaning the refrigerators. During an interview on 8/11/21 at 3:21 PM, the Food service Director stated the nourishment refrigerators need to be monitored both by nursing staff and the dietary department. The nursing staff were responsible to label any food placed in the nourishment refrigerator. The dietary staff should be cleaning the refrigerators weekly and as needed. Housekeeping should be notified if the refrigerators needed to be defrosted. During an interview on 8/11/21 at 3:30 PM, the	F 812	refrigerator/freezer and dating/labeling items when placed in the nourishment room refrigerator/freezer. The Dietary manager and/or dietary aide will check all nourishment room refrigerators/freezers daily to identify need for cleaning and dating/labeling of items. After 72 hours food items will be discarded, unless it is an item with a manufacturer expiration date. At that time, the item will be discarded upon expiration date stamped on the item. Items that are not dated and labeled will be discarded. The dietary manager/aide will wipe out refrigerator/freezer if needed and will notify housekeeping supervisor if freezer is in need of defrosting. The nursing staff will date all items placed in the refrigerator with the residents name and date. After 72 hours food items will be discarded, unless it is an item with a manufacturer expiration date. At that time, the item will be discarded upon expiration date stamped on the item. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Dietary supervisor will audit all nourishment room refrigerators 3 x week for 4 weeks then weekly for 2 months to validate that refrigerators/freezers are clean/defrosted and food items are dated and labeled. The Dietary supervisor will review audits	

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F 812	Continued From page 33 Administrator stated the resident's food should be labelled and dated prior to being placed in the nourishment refrigerators. Staff should follow policy related to resident's food brought in by their families. the Administrator stated the nourishment refrigerators should be cleaned weekly and as needed.	F 812	monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. the Dietary supervisor will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee.	