STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/21/2021

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STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/18/21 through 10/21/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9KS811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/18/21 through 10/21/21. 2 of the 25 complaint allegations were substantiated resulting in deficiencies. Event ID# 9KS811	F 000		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not	F 582		11/18/21

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

Electronically Signed | 11/12/2021

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F 582	Continued From page 1 covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a CMS- 10055 SNF ABN (Centers for Medicare and Medicaid Services Skilled Nursing Facility Advanced Beneficiary Notice) prior to discharge from Medicare Part A skilled services to 2 of 3 residents reviewed for beneficiary protection notification review (Resident #17 and Resident #23).	F 582	On 11/8/21, Admissions Coordinator evaluated the last 30 days of SNF Advance Beneficiary Notices for compliance. The Admissions Coordinator will audit all current residents with SNF Advanced Beneficiary Notices between 10/8/21 to 11/8/21 to ensure proper notification prior	

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F 582	Continued From page 2 Findings included: 1.Resident # 17 was admitted to the facility 01/25/2021 with diagnosis that included hypertension (HTN). A review of the medical record of Resident #17 revealed a CMS-10123 Notice of Medicare Non - Coverage letter (NOMNC) was given to Resident #17 on 03/10/2021 which indicated that Medicare Part A coverage for skilled services would end on 03/10/2021. Resident #17 remained at the facility. A review of the medical record for Resident #17 revealed a CMS - 10055 SNF ABN form was not provided to Resident #17. An interview conducted with the facility resident liaison (RL) on 10/20/2021 at 8:54 AM and revealed that she was not aware that a SNF ABN was required for residents that remained in the facility with remaining Medicare Part A benefit days after skilled services were discontinued required a SNF ABN form. The rehabilitation manager (RM) was interviewed on 10/20/2021 at 10:05 AM. The RM revealed that she was not aware that when a resident no longer received skilled services with remaining Medicare Part A days required a SNF ABN form. On 10/21/2021 at 8:25 AM an interview conducted with the nursing home administrator (NHA) revealed that she expected SNF ABN forms be issued timely and appropriate as the regulation required. 2. Resident #23 was admitted to the facility on 04/06/2021 with diagnoses that included	F 582	to discharge from Medicare Part A skilled services. On 10/28/2021, Director of Corporate Compliance and Corporate Social Worker, provided in-servicing to the Social Work Liaison on SNF Advanced Beneficiary Notice requirements to ensure proper notification prior to discharge from Medicare Part A skilled services. On 10/28/21, Director of Corporate Compliance and Corporate Social Worker provided in-servicing to Administrative Team on the new protocol to review all Part A eligible residents during morning stand up meeting to ensure SNF Advanced Beneficiary Notices are issued prior to discharge from Medicare Part A skilled services. Any staff members who do not receive the training by the specified date of 11/8/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 11/15/21, Admissions Coordinator or designee will conduct 100% weekly audit of SNF Advanced Beneficiary Notices for a period of 90 days to ensure notification prior to discharge from Medicare Part A skilled services. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with the QAPI Committee for a period of 90 days, at which time frequency of monitoring will	

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F 582	Continued From page 3 dementia and atrial fibrillation (AFib). A review of the medical record of Resident #23 revealed a MS-10123 NOMNC was given to the responsible party (RP) that indicated Medicare Part A coverage for skilled services would end on 06/07/2021. Resident #23 remained at the facility. A review of the medical record for Resident #23 revealed a CMS - 10055 SNF ABN form was not provided to Resident #23 or the RP. An interview conducted with the facility RL on 10/20/2021 at 8:54 AM and revealed that she was not aware that a SNF ABN was required for residents that remained in the facility with remaining Medicare Part A benefit days after skilled services were discontinued required a SNF ABN form. The RM was interviewed on 10/20/2021 at 10:05 AM. The RM revealed that she was not aware that when a resident no longer received skilled services with remaining Medicare Part A days required a SNF ABN form. On 10/21/2021 at 8:25 AM an interview conducted with the NHA revealed that she expected SNF ABN forms be issued timely and appropriate as the regulation required.	F 582	be determined by the QAPI Committee.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of	F 676		11/18/21

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F 676	Continued From page 4 daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to provide assistance with daily oral care and provide instruction on proper oral care in accordance with the resident's comprehensive care plan to ensure he maintained or improved on his ability to carry	F 676	On 11/10/21, Resident #3 was seen by the Dentist and Registered Dental Hygienist to address his oral care needs. On 11/11/21 the Interdisciplinary Team reassessed Resident #3□s daily oral care	

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F 676	Continued From page 5 out his own oral hygiene care. This was for 1 of 1 resident with identified dental needs reviewed for activities of daily living. (Resident #3). The findings included: Resident #3 was admitted to the facility on 4/26/19 with a diagnosis which included anoxic brain damage. A review of the quarterly Minimum Data Set (MDS) Assessment dated 10/11/21 coded the resident's cognition as being cognitively intact and he was assessed in the areas of self-care for oral hygiene - the ability to use suitable items to clean teeth with set up assistance with helper sets up or cleans up and resident completes the activity. Resident #3's dental/oral status was assessed as having cavity or broken natural teeth. Resident #3 was coded as having no refusals of care. A review of the Resident #3's active dental care plan with a start date of 5/19/19 revealed a plan of care that read, Resident #3 was at risk for decline in oral health due to natural teeth in poor condition with obvious caries (caries is identified as tooth decay). The care plan revealed a goal that Resident #3 will remain free of oral issues through next review with a review date as 11/11/21. The interventions included "Set up and assist as needed with daily oral care and provide instruction on proper oral care techniques as needed". An observation of Resident #3 on 10/18/21 at 11:50 AM revealed the resident had decaying front teeth. An interview was completed with Resident #3 on 10/20/21 at 9:58 AM who was asked if he had a toothbrush. Resident #3 stated he did not know	F 676	needs and level of assistance he required to maintain or improve on his ability to carry out his own oral hygiene care and updated the resident□s care plan, accordingly. On 10/22/2021, Director of Nursing provided in-servicing to nursing staff working with Resident #3 to provide dental assistance based on his care plan needs. On 11/8/21, Director of Nursing provided in-servicing to nursing staff on providing dental assistance based on each resident□s care plan needs. Any staff members who do not receive the training by the specified date of 11/8/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. On 10/22/21, a facility wide audit was conducted by DON/designee to ensure all residents had the oral hygiene products in place including the basin, toothpaste, and toothbrush. On 11/8/21, a facility wide audit was conducted by DON/designee to determine if residents needed oral hygiene assistance and/or needed to be seen for dental services. Beginning 11/15/21, the Unit Coordinator or designee will conduct weekly audit of dental care being provided based on the care plan 3 times a week x 1 month, 2 times a week x 1 month, then 1 time a	

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F 676	Continued From page 6	F 676		

where his toothbrush was. He indicated they used to bring it to him, but they had not done so in a while. Resident #3 was not able to state when the last time it was that staff had brought his toothbrush. An observation of Resident #3's bathroom sink and cabinet revealed no oral hygiene products in the bathroom and the sink, and the cabinet was empty. With Resident #3's permission, his night-stand drawer was opened and revealed no visible oral hygiene products. The resident was asked if he had a bed bath today and he stated that he had a bed bath this morning and when asked if he brushed is teeth, he stated he had not.

An interview and observation were completed with Nursing Assistant (NA) #5, the NA assigned to Resident #3, on 10/20/21 at 10:06 AM. NA #5 was asked if Resident #3 brushed his teeth after his morning bed bath on 10/20/21. NA #5 revealed oral hygiene care was not completed with Resident #3 that morning because she forgot about it. NA #5 stated the toothbrush is normally set up by staff for Resident #3 and he brushed his teeth himself. NA #5 stated it had been a long time since she had personally watched Resident #3 brush his teeth. NA #5 stated Resident #3 had always been cooperative and would not refuse oral hygiene. NA#5 was asked if she knew where Resident #3's toothbrush was and she opened his night-stand drawer and found a toothbrush in the bottom of his night-stand, however she was not able to find any toothpaste and stated that she would locate some for Resident #3. NA #5 was observed placing Resident #3's toothbrush on his bedside table.

An interview was completed with Nursing Assistant (NA) #4 on 10/20/21 at 10:38 AM who

week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.

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F 676	Continued From page 7	F 676		

stated that Resident #3 was able to brush his own teeth but had refused to do so on some occasions in the past. NA #4 stated that Resident #3 had a small tube of toothpaste in his drawer on Monday 10/18/21. NA #4 stated she had not watched him brush his teeth but had set up his toothbrush for him.

An interview was completed with Nursing Assistant (NA) #6 on 10/20/21 at 3:10 PM who stated that she had never watched Resident #3 brush his teeth but did set up his toothbrush for him. NA #6 was asked where the resident's toothbrush was located, and she stated usually in his drawer. NA #6 was asked if he the resident had toothpaste, and she stated he should have toothpaste in his drawer. NA #6 stated that Resident #3 never had refused cares.

On 10/20/21 at 3:06 PM an observation and interview were completed with Resident #3. Resident #3's bedside table had a plastic pink kidney shaped basin with a toothbrush and toothpaste lying in the basin. Resident #3 was asked if he had brushed his teeth and he said he had.

On 10/21/21 at 8:50 AM an observation and interview were completed with Resident #3. Resident #3 was lying in his bed with a plastic pink kidney shaped basin with a toothbrush and toothpaste lying in the basin. Resident #3 began to brush his teeth and opened the tube of toothpaste and put it on the toothbrush. Resident #3 brushed his teeth but did not spit out any toothpaste and had drank water which he swallowed. Resident #3 was asked if he knew what the plastic pink kidney shaped basin was for and Resident #3 stated to hold his toothbrush and

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F 676	Continued From page 8 toothpaste. Resident #3 was asked if he had ever spit out the water with his toothpaste into the plastic bin and Resident #3 did not respond. An interview was completed on 10/21/21 at 9:57 AM with the Director of Nursing (DON) who stated that it was her expectation that the resident have an observation by facility staff and cueing to complete the oral hygiene tasks daily. DON further stated the facility staff should provide education on the steps for oral hygiene, so the resident learned how to do proper oral care. DON stated that she felt Resident #3 could retain the steps for proper oral hygiene care if provided the education by staff. An interview was completed on 10/21/21 at 10:34 AM with the Administrator who stated it would be her expectation that the facility staff assist residents with oral care every day and follow the care plan as written.	F 676		
F 732 SS=B	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.	F 732		11/18/21

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F 732	Continued From page 9 (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 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 provide actual hours worked by nursing staff for 3 of 7 days reviewed for accurate nurse staffing hours. Findings included: A review of the Posted Daily Nurse Staffing Forms for 10/1/2021 to 10/7/2021 revealed the nurse staffing hours were incorrect for 3 of 7 days: a. On 10/1/2021 the 7:00 pm to 7:00 am shift had 48 hours recorded for the Nurse Aides, but the actual hours were 24 hours.	F 732	On 10/22/21, the Director of Nursing provided in-servicing to the Unit Secretaries on the Posted Nurse Staffing requirements which includes updating the form when staff call out or there are changes to the schedule. Beginning 11/8/21, a new daily process was developed for the Charge Nurse to ensure the adjustment of the staffing sheets with updates to reflect staff call outs or changes to the schedule, to meet the Posted Nurse Staffing requirements. On 11/8/21, Administrator and Director of	

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F 732	Continued From page 10 b. On 10/3/2021 the 7:00 pm to 7:00 am shift had 12 hours recorded for Registered Nurse and 12 hours record for the Licensed Practical Nurses, but the actual hours were 0 hours for the Registered Nurse and 24 hours for the Licensed Practical Nurses. c. On 10/5/2021 the 7:00 pm to 7:00 am shift had 48 hours recorded for Nurse Aides, but the actual hours were 36 hours for the Nurse Aides. An interview with the Unit Secretary on 10/20/2021 at 2:25 pm revealed she was responsible for filling out the Posted Nurse Staffing each morning. She stated she does not update the form when staff call out or there are changes to the schedule. The Unit Secretary stated she did not know who was responsible for updating the Posted Nurse Staffing form when staff call out or the schedule changes. During an interview with the Director of Nursing on 10/20/2021 at 3:38 pm she reviewed the Posted Nurse Staffing Forms and Nursing Schedules for 10/1/2021 to 10/7/2021. The Director of Nursing stated there were discrepancies between the Posted Nurse Staffing hours and available staff recorded on the Nursing Schedules for 10/1/2021, 10/3/2021, and 10/5/2021. The Director of Nursing stated she had not been the Director of Nursing for very long and had not had a chance to work on the process for completing the Daily Nurse Staffing Forms with the nursing staff. The Administrator was interviewed on 10/21/2021 at 10:14 am and stated she was aware of the Posted Nurse Staffing was not accurate for the	F 732	Nursing provided in-servicing to nursing staff on Posted Nurse Staffing requirements. Any staff members who do not receive the training by the specified date of 11/8/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 11/15/21, the Director of Nursing or designee will conduct weekly audit of Posted Nurse Staffing 3 times a week x 1 month, 2 times a week x 1 month, then 1 time a week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 732	Continued From page 11 Posted Daily Nurse Staffing Forms reviewed for 10/1/2021 to 10/7/2021. The Administrator stated the facility should have a process in place to ensure the Posting Daily Nurse Staffing was updated each shift with accurate information.	F 732		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		11/18/21

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F 791	Continued From page 12 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, record review resident and staff interviews, the facility failed to refer a resident with identified dental needs to the dentist. This was for 1 of 2 residents reviewed for dental care. (Resident #3) Findings included: Resident #3 was admitted to the facility on 4/26/19 with diagnoses which included anoxic brain damage and diabetes mellitus. Resident #3's Annual Minimum Data Set (MDS) dated 2/2/21 revealed Resident #3 was a Medicaid recipient and coded Resident #3's cognition as being cognitively intact. Resident #3's dental/oral status was assessed as having cavity or broken natural teeth. A review of the quarterly MDS Assessment dated 10/11/21 coded the resident's cognition as being cognitively intact. A review of Resident #3's dental care plan with a start date of 5/19/19 revealed a plan of care that read, Resident #3 was at risk for decline in oral	F 791	On 11/10/21, Resident #3 was seen by the Dentist and Registered Dental Hygienist to address his oral care needs. On 11/11/2021 the Interdisciplinary Team reassessed Resident #3's daily oral care needs and level of assistance he required to maintain or improve on his ability to carry out his own oral hygiene care and updated the resident's care plan, accordingly. On 10/22/2021, Director of Nursing provided in-servicing to nursing staff working with Resident #3 to provide dental assistance based on his care plan needs. On 11/8/2021, Director of Nursing provided in-servicing to all nursing staff to immediately notify the Director of Nursing of any observed or vocalized dental service needs. On 11/11/21, the Director of Nursing will	

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F 791	Continued From page 13 health due to natural teeth in poor condition with obvious caries. (Caries is identified as tooth decay) The care plan revealed a goal that Resident #3 will remain free of oral issues through next review with a review date as 11/11/21. The interventions included "Refer for Dental exam per resident/resident representative preference". A care plan intervention for diet included mechanical altered regular with soft bite sized meats. A review of the facility's in-house dental clinics for 2020 were scheduled at the facility on 1/3/2020, 7/2/2020 and 7/23/2020. Resident #3 was scheduled to be seen for follow-up/dentures on 7/2/2020 and 7/23/2020 but both clinics were cancelled due to Covid-19. A review of the facility's in-house dental clinics for 2021 revealed one clinic for 7/27/21 but was canceled due to the dental provider not presenting with a negative Covid-19 Polymerase chain reaction (PCR) test. An observation and interview with Resident #3 on 10/18/21 at 11:50 AM revealed the resident had decaying front teeth. Resident #3 stated that I have not had any dental exams due to Covid, but he had told staff that he wanted to have his teeth looked at as he would like to get dentures. An interview was completed on 10/20/21 at 8:59 AM with the Transportation Coordinator (TC) who sets up all the dental services. The TC stated that she would put residents on the schedule if they would get an order from the doctor or if the dental clinics are set up, the TC would ask the resident's family if they would like to have their loved one to be seen. The TC stated if the resident was alert and oriented, we would ask the residents. The TC stated that the dental clinic that was	F 791	provide in-servicing to Administrative nursing staff training on the new notification process for residents requiring dental services. Any staff members who do not receive the training by the specified date of 11/18/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. New notification process includes nursing staff to list the resident's name on the "Services Needed Log" and Director of Nursing to review 5 times weekly during Interdisciplinary Meeting. Nursing administration will make necessary referrals to outside services and determine if that the services needed is emergent, nursing staff will notify nursing administration to arrange an emergent visit. Routine dental clinics are scheduled. Dental clinics are contacted if emergent visits are needed and if an onsite visit cannot be accommodated the facility will send referral to a local dentist. Beginning 11/15/21, the Unit Coordinator or designee will conduct weekly audit of dental care being provided based on the care plan 3 times a week x 1 month, 2 times a week x 1 month, then 1 time a week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee.	

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F 791	Continued From page 14	F 791		

scheduled in July of this year was cancelled as the Administrator stated the facility was not allowed to have dental clinics due to Covid. The dental clinic that was set up for 9/27/21 needed to be canceled as the facility's ownership was requiring a negative PCR Covid test for the providers. The TC stated the dental provider thought they could show their vaccination cards and therefore the clinic needed to be cancelled.

An interview was completed with Resident #3 on 10/20/21 at 9:58 AM who stated that he doesn't have many upper teeth left, but the bottom teeth are Ok. Resident #3 stated that he was not in any pain and has soft foods.

An interview was completed on 10/20/21 at 11:40 AM with the Administrator who was asked why there had not been in dental clinics in 2021. The Administrator stated that the corporation held a planning meeting on 4/15/21 for re-entry of dental services and the plan was not finalized until later in the year. The Administrator stated that it would be her expectation that if a referral was needed for dental services the facility could have sent Resident #3 out of the facility for dental services.

A telephone interview was completed with the dental provider on 10/21/21 at 4:27 PM who stated the facility's corporation had recently made a change. The dental provider stated they had known part of the policy and thought since they were vaccinated, they could show proof of their vaccination cards, however the dental team had been turned away the day of the clinic as they did not have a PCR Covid test.

An interview was completed on 10/21/21 at 9:57 AM with the Director of Nursing (DON) who

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F 791	Continued From page 15 stated that she had been aware many dental clinics were cancelled due to Covid-19. DON stated that it would be her expectation for Resident #3 to be free of any dental issues and to follow up with the facility's dental clinic. The DON stated that if it was an immediate need any resident would be outsourced to an outside dental clinic. The DON stated that it would be her expectation that Resident #3 would have been seen. The DON stated nursing staff could have made a referral and collaborated with the TC to ensure Resident #3 was seen. An interview was completed on 10/21/21 at 10:34 AM with the Administrator who stated it would be her expectation to follow the process that is in place and for nursing to let the dental provider know and for the facility to obtain a referral for Resident #3 to be seen timely. The Administrator stated it was her expectation that Resident #3 should have been seen for dental services. The Administrator stated that if a resident is needing any type of dental services that they could be sent out of the facility for dental services.	F 791		
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	F 812		11/18/21

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F 812	Continued From page 16 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 record review, observations and staff interviews the facility failed to check the expiration dates of thickened liquids maintained in the bedside coolers for 2 of 2 residents reviewed for thickened liquids (Resident # 32 and Resident # 41) and failed to check the temperature of 5 of 5 chicken salad sandwiches prior to plating for the tray line. Findings included: 1.Resident # 32 was admitted to the facility on 12/01/2021 with diagnoses that included post cerebral infarction dysphagia and malnutrition. A review of a significant change Minimum Data Set (MDS) dated 08/23/2021 included that Resident # 32 had a swallowing disorder and received a mechanically altered diet. A review of a care plan for Resident # 32 updated 09/08/2021 revealed that resident # 32 had an increased nutritional and dehydration risk related to history of dysphagia and need for a mechanically altered diet. A review of a physician (MD) order dated 12/01/2020 included in part that Resident # 32 was to receive a puree diet with honey thick	F 812	The expired thickened liquids in Resident #32 and Resident #41 coolers were discarded. The five chicken salad sandwiches were discarded. On 11/8/2021, Director of Nursing audited 100 percent of coolers in resident rooms to ensure no expired thicken liquids were present. On 11/8/2021, Administrator provided in-servicing to all dietary and nursing staff on ensuring residents receive unexpired thickened liquids. Any staff members who do not receive the training by the specified date of 11/8/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. On 10/18/2021, Dietary Manager provided in-servicing to all dietary staff on ensuring the temperature of the chicken salad sandwiches is checked prior to plating for the tray line. Any staff members who do not receive the training by the specified date of 11/8/21 (due to FMLA, leave, etc.)	

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F 812	Continued From page 17 (moderately thick) liquids. A review of a note by the registered dietician (RD) dated 09/21/2021 at 11:13 AM included in part that Resident # 32 received a dysphagia puree diet with moderately thick liquids. On 10/19/21 08:19 AM an observation of Resident # 32's room revealed a blue and white cooler on the nightstand next to the bed that contained 7 pre thickened honey constancy containers inside. Three of the containers were identified to have expiration dates that included 2 clear water containers with expiration dates of 08/25/2021 and another dated 09/15/2021. The cooler also contained a thickened iced tea container with an expiration date of 01/08/2021. The items were removed from the cooler and nursing assistant (NA) # 2 stated that she did replenish thickened liquid items at times from the containers that the dietary staff left in the nourishment refrigerator but that she never looked at the expiration dates and she would have informed the nurse and thrown the items away immediately. An interview conducted with the dietary manager (DM) conducted on 10/1920/21 at 3:29 PM revealed that she was not aware of any expired thickened liquids brought to the nourishment refrigerator by the dietary staff daily. The DM revealed that her expectation was that all food or other items dispensed from the kitchen were to have expiration dates checked prior to being delivered to residents or resident care areas. On 10/20/2021 at 11:28 AM an interview conducted with NA # 4 revealed that she was had removed about 3 to 4 expired thickened liquid	F 812	will be required to complete training prior to working a scheduled shift. This education will be included with new hire orientation. Beginning 10/18/2021, a new protocol will be implemented to check the temperature of the chicken salad sandwiches prior to plating for the tray line and documenting on the temperature log. Beginning 11/15/21, the Unit Coordinator or Director of Nursing will conduct a weekly audit of coolers to ensure thickened liquids are unexpired 3 times a week x 1 month, 2 times a week x 1 month, and then 1 time a week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with Quality Assurance and Performance Improvement (QAPI) quarterly for a period of 90 days. After 90 days, the frequency of monitoring will be determined by the QAPI Committee. Facility Administrator is responsible for overall implementation of the plan of correction. Beginning 11/15/21, Regional Dietary Manager for Long Term Care or Dietary Kitchen Manager will conduct a weekly audit to ensure cold items are at the proper temperature prior to plating for the tray line. Logs will be reviewed and validated 3 times a week x 1 month, 2 times a week x 1 month, and then 1 time a week x 1 month. Any identified issues	

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F 812	Continued From page 18 items from the bedside cooler of Resident # 32 and threw the items away immediately. NA #4 revealed that the nurse at that time witnessed the episode but that she was not certain who the nurse was or the specific date. The nursing home administrator (NHA) was interviewed on 10/21/2021 at 8:25 AM. The NHA stated that it was her expectation that all bedside coolers that contained thickened liquids have at least daily checks of the expiration dates of the items and if expired items were identified the items be disposed of immediately and that the director of nurses (DON) or NHA be notified immediately. #2. Resident # 41 was admitted to the facility on 04/09/2021 with diagnoses that included vascular dementia and dysphagia. A review of a quarterly MDS dated 09/29/2021 revealed that Resident # 41 received a mechanically altered diet. A review of MD order summary dated 10/01/2021 included an order written 04/09/2021 that Resident # 41 was to receive a dysphagia puree diet with mildly (honey) thick liquids. An interview conducted with the DM on 10/19/2021 at 3:29 PM revealed that she was not aware of any expired thickened liquids brought to the nourishment refrigerator by the dietary staff daily. The DM revealed that her expectation was that all food or other items dispensed from the kitchen were to have expiration dates checked prior to being delivered to residents or resident care areas.	F 812	will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days. After 90 days, the frequency of monitoring will be determined by the QAPI Committee. Facility Administrator is responsible for overall implementation of the plan of correction.	

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On 10/20/2021 at 11:28 AM an interview conducted with NA # 4 revealed that she was not aware of expired items in the blue thickened liquid items in the room of Resident # 41. NA # 4 revealed that if she had noted expired items in the cooler, she would have removed the item immediately and reported the concern to the nurse.

The NHA was interviewed on 10/21/2021 at 8:25 AM. The NHA stated that it was her expectation that all bedside coolers that contained thickened liquids have at least daily checks of the expiration dates of the items and if expired items were identified the items be disposed of immediately and that the DON or NHA be notified immediately.

3. An observation was conducted in the kitchen on 10/18/21, which started at 11:58 AM. During the observation the food for the resident ' s meal was checked for appropriate holding temperatures. The cook completed checking the temperatures of foods in the steam table and at 12:16 PM she and the other dietary staff started to plate and tray the resident ' s meals for lunch. The alternate for lunch was a chicken salad sandwich. There were 5 chicken salad sandwiches, they were wrapped in plastic wrap, and were in a pan placed on top of another pan with ice in it. One of the sandwiches, in the pan, had been placed on top of a clear plastic container containing a lettuce salad which was also in the pan, and the other 4 were stacked vertically so that only the bottom edge of the sandwich was in contact with the cooled surface of the pan. The Dietary Aide (DA) was observed plating the sandwich which had been sitting on

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top of the salad container for a resident. The DA stated they had "never" checked the salad of the chicken salad sandwiches. The DA was observed to check the temperature and the temperature of the chicken salad of the sandwich was observed to have been 56 degrees Fahrenheit. The DA stated she would dispose of the sandwich. She further explained the sandwiches had come right out of the refrigerator and they had been made not too long before they started the tray line for lunch. The DA was then observed checking a second sandwich which had been sitting on the chilled tray and the chicken salad of the sandwich was observed to have been 51 degrees Fahrenheit.

An interview was conducted on 10/18/21 at 12:42 PM with the DA and she stated she should have checked the temperature of the chicken salad in the sandwiches when they did the other food temperatures prior to starting the tray line.

An interview was conducted on 10/18/21 at 12:46 PM with the cook and she stated they had not been checking the temperature of the chicken salad sandwiches. She said the sandwiches had been made at about 11:00 AM and then had been placed in the 2-door cooler until they were brought out for the lunch line. She said the temperature of the chicken salad sandwiches should have been checked because the chicken salad is a perishable food and needed to stay cold.

An interview was conducted on 10/18/21 at 12:48 PM with the Dietary Manager (DM) and the Dietary Consultant (DC). The DC stated the sandwiches should have been checked when the other temperatures were checked for the tray line.

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F 812	Continued From page 21 She further stated the chicken salad in the sandwiches should have been in the range of 32 to 40 degrees Fahrenheit. The DM stated they would keep the chicken salad sandwiches in the 2-door cooler and remove each sandwich as needed in order to keep the sandwiches at a proper temperature. During an interview conducted on 10/20/21 at 10:08 AM the Administrator stated her expectation was for food to be kept in the appropriate temperature range for cold and hot foods. She said the chicken salad sandwiches were out of the safe temperature range and the temperature should have been checked prior to the food being plated for the resident. She said all perishable foods should be checked for proper temperature prior to the start of the tray line and a log for temperature of all perishable foods had been implemented after the deficient practice was identified.	F 812		