STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/31/22 through 06/03/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #G57811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/31/22through 06/03/22. Event ID# G57811. The following intake was investigated, NC00188407. One of the 4 complaint allegations was substantiated resulting in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and Physician interviews, the facility failed to assess and document a resident's ability to self-administer medication for 1 of 1 resident (Resident #1) who was observed to have medications at bedside. Findings included: Resident #1 was admitted to the facility on 5/20/21 with diagnoses which included Diabetes Mellitus, bipolar disorder, and congestive heart failure.	F 554	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 554 Corrective Action for Affected Residents	7/1/22

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

Electronically Signed | 06/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 554	Continued From page 1 Resident #1's annual Minimum Data Set dated 5/07/22 indicated she was cognitively intact and was independent or supervision only for most activities of daily living. Record review indicated Resident #1 had no self-administration of medication assessment. Review of Physician's orders revealed no orders for self-administration of medications or for medications to be kept at bedside. The active physician's orders for Resident #1 included, in part, the following medications: - Risperidone (antipsychotic) - Cymbalta (antidepressant) - Linzess (constipation) - Magnesium (supplement) - Multi-vitamin (supplement) - Plaquenil (auto-immune) - Spironolactone (diuretic) - Demadex (diuretic) - Glucophage (antidiabetic) - Otezla (antirheumatic) - Protonix (stomach acid suppressant) - Topiramate (anticonvulsant/antimigraine) - Buspirone (antianxiety) - Keflex (antibiotic) - Phenazopyridine (urinary tract analgesic) - Potassium (supplement) Review of Resident #1's care plan revealed no mention of self-administration of medications. Observation of Resident #1 and an interview were conducted on 5/31/22 at 11:54 AM and revealed 2 medication cups with pills in them on her bedside table by her recliner. Resident #1 stated one cup was her morning medications (Cardizem, Cymbalta, Linzess, Magnesium, Multi-Vitamin,	F 554	On 5/31/2022, the Director of Nursing re-educated Nurse #3 on safe medication administration and not leaving the resident's room until she had ensured all medications were taken as ordered. On 6/21/2022, the Director of Nursing completed a Self-Administration Assessment for resident #1. Corrective Action for Potentially Affected Residents On 5/31/2022, a 100% audit of resident's rooms was completed by the Director of Nursing and Administrator to ensure no medications were present at the bedside. There were no negative findings. All residents that administer their own medications have the potential to be affected by this alleged deficient practice. On 6/21/2022, the Director of Nursing met with the IDT team and completed a 100% audit to determine if any residents were clinically appropriate to self-administer medications. Results of audit: Zero residents are clinically appropriate to self-administer medications. Systemic Changes On 5/31/2022, the Director of Nursing began in-servicing all current Licensed Nurses and Med Aides. This in-service included the following topics: • Safe Medication Administration • When to complete a Self-Administration Assessment The Director of Nursing or designee will complete Medication Observations on all licensed nurses and med aides to ensure safe medication administration. The Director of Nursing will ensure that any Licensed Nurse or Med Aide who has	

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F 554	Continued From page 2	F 554		

Plaquenil, Risperidone, Spironolactone, Demadex, Glucophage, Otezla, Protonix, Topiramate, Buspirone, Keflex, and Phenazopyridine) and the other was her morning potassium pills.

An interview on 5/31/22 at 2:24 PM with Nurse #3 revealed her normal medication administration process for Resident #1 was that she made 3 medication cups for Resident #1's morning medications. She stated she put the narcotic pills in one, potassium pills in one, and all other morning pills in the 3rd. Nurse #3 stated she observed Resident #1 taking the narcotic pills from the cup but left the other 2 medication cups at the resident's bedside for her to take on her own. She stated the resident took a large number of pills and she did this for time management as the resident spent more than 30 minutes taking her morning medications. She also stated that she had not notified the physician or completed a self-administration assessment.

An interview on 5/31/22 at 5:51 PM with the Director of Nursing (DON) revealed that residents should be observed while taking medications unless they were assessed for self-administration of medications. She confirmed that Resident #1 did not have a self-administration assessment or a Physician's order for self-administration of medications.

An interview on 6/02/22 at 2:57 PM with the Physician revealed that he believed Resident #1 should be observed when she took her medications.

An interview on 6/2/22 at 8:56 AM with the Administrator revealed that Resident #1's

not received this training by 7/1/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurse's and Med Aides.
Quality Assurance
The Director of Nursing will monitor this issue using the Survey Quality Assurance Tool for Monitoring Safe Medication Administration. The monitoring will include completing med pass observations. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker.

Date of compliance: 7/1/2022

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F 554	Continued From page 3 medications should not have been left in her room and the nurse should have observed her taking her medications to ensure they were taken.	F 554		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interviews, the facility failed to provide the specialized services in accordance with Pre-Admission Screening and Resident Review (PASARR) report recommendations for 1 of 1 resident (Resident #9) reviewed for PASARR level II. Findings included: Review of Resident #9's PASARR level II	F 644	F644 Coordination of PASARR and Assessments Corrective actions for Resident # Resident #9 was evaluated for individual psychotherapy on 06/06/2022. The Licensed Clinical Social Worker recommended for Resident to receive follow up psychotherapy. Resident #9 was evaluated by a Physical Therapist on 06/03/2022. The Physical Therapist recommended for the Resident to receive	7/1/22

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F 644	Continued From page 4 Determination Notification dated 11/12/19 revealed he was assessed to be a PASARR level II resident. It further revealed this PASARR level II determination had no expiration date. The notification indicated Resident #9 was to receive individual/group psychotherapy, follow-up psychiatric services by a psychiatrist, and restorative nursing when not in active Physical Therapy (PT). Resident #9 was admitted to the facility on 6/04/21 with diagnosis of schizophrenia. Resident #9's quarterly Minimum Data Set (MDS) dated 3/02/22 indicated he had moderately impaired cognition and required extensive assistance or total dependence for most activities of daily living. Review of Resident #9's electronic health record revealed he was currently receiving psychiatric services by a psychiatrist. Further review revealed he was not receiving any individual or group psychotherapy, restorative nursing or PT. An interview on 6/02/22 at 3:44 PM with the Social Worker (SW) revealed she reviewed the PASARR's for transfer and admission residents. She stated that since this resident was transferred from a sister facility she did not review his PASARR to see if he was supposed to receive specialized services. An interview on 6/02/22 at 2:57 PM with the Physician revealed that the residents should receive the specialized services determined by the PASARR or the facility should have the PASSAR reevaluated.	F 644	physical therapy. The Resident received 6 sessions of physical therapy. Physical Therapy recommended Resident to participate in a functional maintenance program. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of all current residents level 11 pasarrs was conducted to ensure the facility is providing any specialized services in accordance with Pre-admission Screening and Resident Review(PASAAR) recommendations. Audit results are: • ___2 of __8_ residents who had a Level II PASARR were noted to have negative findings. All residents who were identified in the audit as not meeting the regulatory standard were corrected. This was completed by the facility Social Services Director on 06/23/2022. Systemic Changes Residents that are newly admitted with a level 11 PASAAR will be reviewed to determine if any specialized services in accordance with Pre-admission Screening and Resident Review(PASAAR) are being recommended. On 06/23/2022, the facility Social Services Director and Minimum Data Set Nurse	

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F 644	Continued From page 5 An interview on 6/02/22 at 8:53 AM with the Administrator confirmed that Resident #9 was not currently receiving individual or group psychotherapy, restorative or PT. She stated she was unaware that he required specialized services as determined by the PASARR and they had been missed when he was transferred to the facility.	F 644	received an in-service training by the Administrator. This in-service included the importance of thoroughly reviewing each resident's PASAAR level and if it is a level 11, review to see if any specialized services in accordance with Pre-admission Screening and Resident Review(PASAAR) are being recommended. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator or designee will begin auditing newly admitted Residents with a level 11 PASAAR to determine if any specialized services in accordance with Pre-admission Screening and Resident Review(PASAAR) are being recommended. The audit tool used will be the quality assurance survey tool entitled "PASARR Screening Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Social Services, Support Nurse, Therapy, Health Information Manager, Dietary Manager	

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F 644	Continued From page 6	F 644	and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: July 1, 2022	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		7/1/22

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F 655	Continued From page 7 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan within 48 hours of admission for one of two new admissions reviewed. (Resident #198) Findings included: Resident #198 was admitted to the facility on 05/26/2022 with diagnoses including long term use of insulin, major depressive disorder, and anxiety. A review of Resident #198's medical record did not reveal any evidence a baseline care plan was completed within 48 hours of her admission to the facility. On 06/01/2022 at 3:47 PM an interview with the Social Worker (SW) indicated either the floor nurse or the Minimum Data Set (MDS) Nurse completed resident's baseline care plans. On 06/02/2022 at 2:25 PM an interview with	F 655	F655 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Plan for correcting specific deficiency. The process that led to deficiency cited. The facility failed to develop a baseline care plan within 48 hours of admission for one of two new admissions reviewed. (Resident #198) A review of Resident #198□s medical	

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

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F 655	Continued From page 8 Nurse #1 indicated she was assigned to care for Resident #198 on 05/27/2022 and 05/28/2022 on the 7AM-7PM shift. She stated nurses entered physician orders and completed a nursing admission assessment for new residents. She further indicated nurses did not complete residents' baseline care plans. Nurse #1 stated she did not know who did those. On 06/03/2022 at 9:26 AM an interview with Nurse #6 indicated she was assigned to care for Resident #198 on 05/26/2022 when she was admitted to the facility. She stated the MDS Nurse completed residents' baseline care plans. She went on to say based on the physician's orders and nursing admission assessment, nurse aides were provided information by the nurse in report on how to care for newly admitted residents. On 06/02/2022 at 2:33 PM an interview with MDS Nurse #1 indicated she had been in training since 05/05/2022. She stated she had not completed any residents' baseline care plans. She went on to say MDS Coordinator #2 had been doing what she couldn't do and may have been doing this. On 06/02/2022 at 3:19 PM a telephone interview with MDS Nurse #2 indicated she did not complete residents' baseline care plans. She stated she was a corporate employee working remotely for the facility. She went on to say someone from the facility completed residents' baseline care plans. On 06/02/2022 at 3:50 PM in an interview the Director of Nursing (DON) confirmed Resident #198 had no completed baseline care plan. She stated she thought MDS Nurse #2 was doing	F 655	record did not reveal any evidence a baseline care plan was completed within 48 hours of her admission to the facility. The procedure for implementing the acceptable plan of correction- for the specific deficiency cited: - Resident #198 had a baseline care plan completed on 6/7/22. Corrective action for residents with the potential to be affected by the deficient practice: All residents have the potential for being affected by the above alleged deficient practice. On 6/7/22, the DON completed a 100% audit of all residents who have been admitted to the facility during the past 30 days to validate whether or not a Baseline Care Plan had been completed within 48 hours of admission and if the Baseline Care Plan was reviewed with the resident or not. The audit results are as follows: 10 of 12 residents reviewed were identified as not having had a Baseline Care Plan completed as required. On 6/7/22, All residents who were identified as not having the Baseline Care Plan requirement met were provided a written summary of his/her Baseline Care Plan if they were still a current, active Resident residing in the facility. Systemic Changes On 6/21/2022, the Minimum Data Set Nurse and Director of Nursing received education on requirements for completion	

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F 655	Continued From page 9 them. She went on to say the facility would need to come up with a new process to ensure residents had baseline care plans completed within 48 hours of admission. On 06/03/2022 at 10:23 AM an interview with the Administrator indicated residents should have a baseline care plan completed within 48 hours of admission to the facility. She stated in the past the MDS Nurse had done those. She went on to say the facility would be implementing a new process to ensure they were completed.	F 655	of the Baseline Care Plan. This education reviewed CMS requirements for ensuring that the Baseline Care Plan requirement be met for all newly admitted residents including the following: Baseline Care Plan Requirement: The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must: 1. Be developed within 48 hours of a resident□s admission. 2. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: ¿ Initial goals based on admission orders. ¿ Physician orders. ¿ Dietary orders. ¿ Therapy services. ¿ Social services ¿ PASARR recommendation, if applicable. Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR ¿483.21(a)). In many cases, interventions to meet the resident□s needs will already have been	

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F 655	Continued From page 10	F 655	implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident□s problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days). The baseline care plan will be completed by the Director of Nursing or designee. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing, Administrator or designee will review 5 random residents who have been admitted to the facility in order to determine if the Baseline Care Plan was completed during the required timeframe. This audit will be completed using the Quality Assurance audit tool entitled Baseline Care Plan Completion Audit. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information	

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F 655	Continued From page 11	F 655	Management, Dietary Manager and the Administrator The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: 7/1/2022	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		7/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345404	A. BUILDING _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 12 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and Physician interviews, the facility failed to have Physician's orders for the use of a urinary catheter for 1 of 2 residents reviewed for urinary catheter (Resident #9). Findings included: Resident #9 was admitted to the facility on 6/04/21 with diagnoses which included urinary retention. Resident #9's quarterly Minimum Data Set (MDS) dated 3/02/22 indicated he had moderately impaired cognition and required extensive assistance or total dependence for most activities of daily living. Review of nurse's progress noted dated 5/22/22 at 10:27 PM indicated that Resident #9 had no urine output during the shift. Review of nurse's progress note dated 5/23/22 at 6:35 AM indicated the urinary catheter was inserted due to urinary retention. Observation of Resident #9 on 5/31/22 at 11:30 AM revealed he had a urinary catheter. Observation of Resident #9 on 6/02/22 at 9:30 AM revealed he had a urinary catheter.	F 690	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F690 Corrective Action for Affected Residents On 6/1/22, the Director of Nursing obtained a Physician's Order for Resident #9's catheter. Corrective Action for Potentially Affected Residents All residents that have catheters have the potential to be affected by this alleged deficient practice. On 06/21/2022, The Director of Nursing audited 100% of all catheters to ensure that all residents with Catheters had an appropriate physician order. No negative findings noted. Systemic Changes On 06/17/22 the Director of Nursing began in-servicing all current Licensed Nurses. This in-service included the following topics:	

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	345404	A. BUILDING _____ B. WING _____	C 06/03/2022

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F 690	Continued From page 13 Review of Resident #9's Physician's orders revealed no orders for a urinary catheter. An interview on 6/02/22 at 8:59 AM with the Director of Nursing confirmed Resident #9 did not have an order for a urinary catheter. She stated there should have been a Physician's order for the urinary catheter, but it had just been missed. An interview on 6/02/22 at 2:57 PM with the Physician revealed that Resident #9 should have an order for a urinary catheter which included orders for the urinary catheter to be changed and flushed. An interview on 6/02/22 at 9:00 AM with the Administrator confirmed that Resident #9 should have had an order for a urinary catheter.	F 690	• The importance of ensuring to obtain orders for care and treatment of the resident as necessary. The Director of Nursing will ensure that any Licensed Nurse who has not received this training by 7/1/2022 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all Licensed Nurses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or designee will monitor this issue using the Survey Quality Assurance Tool for Monitoring Physician orders for Catheters. The monitoring will include resident observation and reviewing physician orders. This will be completed weekly for 4 weeks then monthly times 2 months or until resolved by Quality of Life/Quality Assurance Committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life Committee consists of the Administrator, Director of Nursing, Assistant DON, Staff Development Coordinator, Unit Support Nurse, MDS Coordinator, Business Office Manager, Health Information Manager, Dietary Manager and Social Worker. Date of compliance: 7/1/2022	
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		7/1/22

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	345404	A. BUILDING _____ B. WING _____	C 06/03/2022

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F 756	Continued From page 14 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and	F 756	F756	

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F 756	Continued From page 15 consultant pharmacist (CP) interviews, the facility failed to act upon pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications (Resident #1). Findings included: Resident #1 was admitted to the facility on 5/20/21 with diagnoses which included bipolar disorder. Review of the electronic health record revealed an Abnormal Involuntary Movement Scale (AIMS) had been completed on Resident #1 on 5/20/21. AIMS is used to assess abnormal body movements in residents taking antipsychotic medications. Resident #1's annual Minimum Data Set dated 5/07/22 indicated she received an antipsychotic medication for 7 days during the look back period. The consultant pharmacist (CP) monthly drug regimen review for Resident #1 dated 12/28/21 included a recommendation for an Abnormal Involuntary Movement Scale (AIMS) to be completed. The CP monthly drug regimen review for Resident #1 dated 1/30/22 included a recommendation for an Abnormal Involuntary Movement Scale (AIMS) to be completed. The CP monthly drug regimen review for Resident #1 dated 2/25/22 included a recommendation for an Abnormal Involuntary Movement Scale (AIMS) to be completed. The CP monthly drug regimen review for	F 756	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: On 4/4/2022, an Antipsychotic Review and AIMS was completed for Resident #1 by the Support Nurse. Findings were no harm noted to resident #1. On 6/20/2022 the Director of Nursing was educated by the Quality Assurance Nurse Consultant on completing Drug Regimen Reviews timely. Corrective action for residents with the potential to be affected by the deficient practice: All residents have potential to be affected. On 6/22/2022, the Director of Nursing and designee completed an audit to ensure all residents last 3 months of Drug Regimen Reviews were completed. Audit results: One resident was missing a completed pharmacy drug regimen review. Recommendation was completed on 6/23/22. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 06/20/2022 the Quality Assurance Nurse Consultant educated the Director of Nursing on:	

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F 756	Continued From page 16 Resident #1 dated 3/26/22 included a recommendation for an Abnormal Involuntary Movement Scale (AIMS) to be completed. Review of the electronic health record revealed an AIMS had been completed on Resident #1 on 5/20/21. An interview on 6/03/22 at 10:12 AM with the CP confirmed she had recommended an AIMS be completed for Resident #1 on her Medication Regimen Reviews completed on 12/28/21, 1/30/22, 2/25/22, and 3/26/22. She stated an AIMS should be completed on Resident #1 every 6 months to monitor medication side effects and it should have been completed in November 2021. The CP explained she provided a copy of her recommendations as well as discussed the recommendations with nursing staff during each visit. An interview on 6/02/22 at 8:59 AM with the Director of Nursing (DON) confirmed Resident #1 did not have an AIMS assessment completed every 6 months. She stated she was responsible for ensuring the CP recommendations were completed. She stated she had recently established a process to ensure the pharmacy recommendations were acted on in a timely manner. The DON stated their electronic health record system did not automatically flag the staff to complete an AIMS every 6 months and she had not ensured it was done. An interview on 6/02/22 at 10:45 AM with the Administrator confirmed that Resident #1 should have had an AIMS completed every 6 months and it had just been missed.	F 756	The importance of completing Pharmacy Recommendations timely and Psychotropic Drug Policy. The Quality Assurance Nurse Consultant will ensure that any newly hired Directors of Nursing completes education on this topic related to Plan of Correction during orientation. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: The Quality Assurance Nurse Consultant will monitor Compliance with the regulatory requirements utilizing F 756 Drug Regimen Review QA monitoring tool. Monitoring will include checking to ensure all recommendations are completed timely. This QA monitoring tool will be completed Weekly times 4 weeks, then monthly x 3 months. The findings will be reported in the weekly Quality Assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 7/1/2022	

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F 758	Continued From page 17	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		7/1/22

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F 758	Continued From page 18 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to obtain an Abnormal Involuntary Movement Scale (AIMS) prior to the initiation of an antipsychotic medication. This was for one of five residents reviewed for unneccesary medication. (Resident #34) Findings included: Resident #34 was admitted to the facility on 11/04/2020 with diagnoses including dementia with behaviors, schizoaffective disorder (a mental health disorder) and drug induced subacute dyskinesia (uncontrolled involuntary muscle movements). A review of the quarterly Minimum Data Set (MDS) assessment for Resident #34 dated 04/29/2022 revealed she was moderately cognitively impaired. No antipsychotic medications were used during the seven day look back period of the assessment. A review of a psychiatric follow up note for Resident #34 dated 05/16/2022 revealed Resident #34 was hallucinating and having	F 758	F758 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Corrective action for resident(s) affected by the alleged deficient practice: On 6/1/2022 an Antipsychotic Review and AIMS was completed for Resident #34 by the assigned hall nurse. Findings were no harm noted to resident #34. On 6/19/2022, the Director of Nursing began reeducating all licensed nurse's including Nurse #5 on ensuring AIMS assessments are completed prior to the start of a new antipsychotic medication. Corrective action for residents with the potential to be affected by the deficient	

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F 758	Continued From page 19	F 758		

delusions. This was extremely upsetting to Resident #34. The plan was to begin Seroquel (an antipsychotic medication) 25 milligrams (mg) at bedtime daily for schizoaffective disorder and dementia with delusions and hallucinations. The note further revealed the recommendations were provided to Resident #34's facility physician (MD) on 05/19/2022 and he agreed with the plan.

A review of the May 2022 Medication Administration Record (MAR) for Resident #34 revealed a physician's order dated 05/19/2022 for Seroquel 25 mg at bedtime daily for schizoaffective disorder. It further revealed Resident #34 received this medication at bedtime on 05/20/2022 through 05/31/2022. Behavior monitoring for delusions and antipsychotic medication side effect monitoring was completed each shift.

A review of Resident #34's medical record did not reveal evidence an AIMS test was conducted prior to starting the antipsychotic medication on 05/20/2022.

On 06/01/2022 at 4:19 PM an interview with Nurse #5 indicated she entered the physician's order dated 05/19/2022 for Seroquel 25 mg at bedtime daily for Resident #34. She stated she knew she should have completed an AIMS for Resident #34 when the medication was ordered but she missed it. She stated an AIMS should have been done prior to starting this medication to establish a baseline for Resident #34's involuntary movements so if Resident #34 developed any new or worsening symptoms the facility would be aware of them.

On 06/02/2022 at 11:03 AM a telephone interview

practice:
All resident receiving antipsychotic medications have potential to be affected. On 6/2/22, the Director of Nursing completed an audit to ensure all residents prescribed an antipsychotic medication had a completed Antipsychotic Review and an up to date AIMS assessment within the last six months. Audit results: 4 of 8 residents prescribed an antipsychotic did not have an Antipsychotic Review and AIMS assessments completed as required. Assessments were completed by 6/3/2022.
Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
On 06/19/2022 the Director of Nursing began educating all full time, part time, and PRN Nurse's on the following topics: Importance of completing an AIMS assessment prior to the start of an Antipsychotic Medication and the policy on Psychotropic Drugs.
The Director of Nursing will ensure that any Licensed Nurse who has not received this training by 7/1/2022 will not be allowed to work until the training is completed. The Director of Nursing will ensure that any newly hired nurse will receive the education upon orientation.
Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements:
The Director of Nurses or designee will monitor Compliance with the regulatory requirements utilizing F 758 Unnecessary Medications QA monitoring tool.

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THREE RIVERS HEALTH AND REHAB	1403 CONNER DRIVE WINDSOR, NC 27983

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F 758	Continued From page 20 with the facility's Registered Pharmacist (RPh) indicated the purpose of a baseline AIMS was to establish whether the resident had any abnormal involuntary movements prior to starting an antipsychotic medication. She stated she did not think a week or two of Resident #34 receiving the antipsychotic medication prior to a baseline AIMS would have any impact on the accuracy of the testing. On 06/02/2022 at 11:48 AM a follow up telephone interview with the RPh indicated the facility had been monitoring for side effects of the antipsychotic medication since initiating it. She stated typically it would take some time after initiating an antipsychotic medication for any involuntary movement side effects to develop. She went on to say a week or two of receiving antipsychotic medication prior to a baseline AIMS did not put Resident #34 at risk for any harm. She went on to say she would expect the facility to conduct a baseline AIMS as soon as possible after starting an antipsychotic medication and then every 6 months thereafter. On 06/02/2022 at 1:21 PM an interview with the Director of Nursing (DON) indicated the facility should be following it's Antipsychotic Drugs policy which was to obtain an AIMS prior to starting an antipsychotic medication. On 06/02/2022 at 3:04 PM an interview with Resident #34's physician (MD) indicated the facility should be following it's Antipsychotic Drugs policy for obtaining an AIMS prior to starting an antipsychotic medication unless the medication was ordered on an emergent basis. He stated if the medication was ordered emergently, he would expect the AIMS to be done as soon as possible after. He went on to say Resident #34's antipsychotic medication was not ordered	F 758	Monitoring will include checking to ensure all AIMS are completed per policy. This QA monitoring tool will be completed Weekly times 4 weeks, then monthly x 3 months. The findings will be reported in the weekly Quality assurance (QA) meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Wound Nurse, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 7/1/2022	

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F 758	Continued From page 21 emergently. On 06/03/2022 at 10:23 AM an interview with the Administrator indicated the facility should be following it's Antipsychotic Drugs policy for obtaining an AIMS.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to store an unopened	F 761	The statements made on this plan of correction are not an admission to and do	7/1/22

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F 761	Continued From page 22 Insulin Lispro Injection Kwik Pen according to the manufacturer's guidelines and the facility's policy. This was for one (400 Hall) of two medication storage rooms reviewed. Findings included: A review of the manufacturer's instructions for use of the Insulin Lispro Injection Kwik Pen revealed in part "Store unused pens in the refrigerator between 36 degrees Fahrenheit and 46 degrees Fahrenheit". An undated facility policy titled "Medication Storage in the Facility", provided by the facility, read in part "Medications requiring refrigeration or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator with a thermometer to allow temperature monitoring". On 06/01/2022 at 9:33 AM an observation of the 400 Hall medication storage room was conducted with Nurse #1. A refrigerator in the medication room which was not plugged in or functioning was observed to contain an unopened Insulin Lispro Injection Kwik Pen labeled "Refrigerate until opened". A pharmacy label on the Kwik Pen indicated it was dispensed on 05/31/2022. An interview with Nurse #1 at that time indicated pharmacy delivery of medication occurred on the 11PM-7AM shift. She stated she did not know why the unopened Kwik Pen was in the non-functional refrigerator. She stated it should have been stored in the 400 Hall medication refrigerator which was plugged in and had temperature monitoring in place. She went on to say she could not say how long the Kwik Pen had been in the non-functional refrigerator. Nurse #1	F 761	not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F761 Corrective Action for Affected Residents 1. On 6/1/2022, the Insulin Lispro Injection Kwik Pen was removed from unplugged refrigerator. On 6/1/2022 the Maintenance Director removed the refrigerator from the Med room. Nurse #2 was educated on the appropriate way to store insulin pens on 06/19/2022. No resident was identified to be affected. Resident never received any insulin from the pen. Corrective Action for Potentially Affected Residents A 100% Audit of all medication room refrigerators was completed on 6/1/2022. All refrigerator temperatures were appropriate and no other insulin pens were stored inappropriately. Systemic Changes All licensed nurses will be re-educated by the Director of Nursing on facility Medication Storage policy, this will be completed by 7/1/2022. Quality Assurance The Director of Nursing or designee will audit refrigerators weekly for 4 weeks and then monthly for 3 months for compliance with monitoring Storage of medication in	

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	345404	A. BUILDING _____ B. WING _____	C 06/03/2022

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F 761	Continued From page 23 further indicated the Kwik Pen did not feel cool to the touch. On 06/01/2022 at 9:51 AM observation of the 400 Hall medication storage room was conducted with the Maintenance Director. An interview at that time indicated he did not know why the non-functional refrigerator was in the 400 Hall medication room. He stated it was not plugged in. He went on to say he did not perform any routine maintenance or inspection of medication storage refrigerators. He further indicated he had not received any work orders for the 400 Hall medication room. On 06/01/2022 at 1:01 PM a telephone interview with Nurse #2 indicated she received the Insulin Lispro Injection Kwik Pen dispensed by the pharmacy on 05/31/2022 on the 11PM-7AM shift on that date. She stated she knew unopened insulin pens required refrigeration. She went on to say the 400 Hall medication storage room had two refrigerators. She further indicated one was plugged in, functional and had a thermometer for monitoring the temperature. She stated the second refrigerator was not plugged in. Nurse #2 went on to say this second refrigerator used to be for storing resident food items but was no longer being used. She further indicated she remembered placing the Kwik Pen in the functional refrigerator. Nurse #2 stated she did not know how it got into the other refrigerator. On 06/01/2022 at 2:16 PM an interview with the Director of Nursing (DON) indicated if the label on the insulin Kwik Pen instructed to refrigerate until it was opened then it should have been refrigerated. She stated she was familiar with the 400 Hall medication room. She went on to say	F 761	each refrigerator. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, MDS Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director, and the Director of Social Services. Compliance date: 7/1/2022	

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F 761	Continued From page 24 there were two refrigerators but only one was being monitored for temperature and used for storing medications. She further indicated the facility would remove the other refrigerator now to avoid any confusion in the future. On 06/03/2022 an interview with the Administrator indicated the insulin Kwik Pen should not have been in the non-functioning 400 Hall medication room refrigerator.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the Dietary Manager and record review the facility failed to store foods in the refrigerator after opening, failed to discard an expired food item,	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.	7/1/22

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F 812	Continued From page 25 and failed to maintain pasta salad at or below 41 degrees Fahrenheit during 2 of 3 kitchen observations. This had the potential to affect 43 residents who received meal trays out of 45 total residents. The findings included: 1. On 5/31/22 at 9:25 AM an opened gallon size container of diced pickles was observed stored in the room temperature storage room. An open date was not observed on the container. The manufacturer label read the product was to be refrigerated after opening. On 5/31/22 at 9:26 AM an opened gallon size container of Bar B Que sauce was observed stored at room temperature in the storage room. The container had an open date of 3/23/22. The label read the product was to be refrigerated after opening. On 5/31/22 at 9:30 AM an unopened box of pancake mix was observed stored for use on the shelf with other foods. The pancake mix had an expiration date of 2/18/22. On 5/31/22 at 9:25 AM the Dietary Manager stated the diced pickles, the Bar B Que sauce and the pancake mix were not properly stored and needed to be discarded. 2. On 6/1/22 at 11:45 AM Cook #1 used a calibrated thermometer when she checked the temperature of the large stainless steel bowl of pasta salad. The temperature on the thermometer read 60 degrees Fahrenheit. The cook stated she made the pasta salad earlier that morning and stored it in the walk-in refrigerator.	F 812	To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 1. For dietary services, a corrective action was obtained on 6/1/2022. 1. The Dietary Service Manager discarded dice pickles, BBQ sauce, and pancake mix on 5/31/22. 2. The Dietary Service Manager placed pasta salad in a bowl of ice to decrease temperature on 6/1/22. On 6/1/22 the Dietary Service Director re educated Cook #1 on Serving Cold Foods. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 5/31/22, the Dietary Service Manager completed a kitchen walk through to ensure all food items were within their dates, labeled, and stored appropriately. 3. Systemic changes In-service education was provided to all full time, part time, and as needed dietary staff on and 06/17/22 by the Dietary Service Manager. Topics included:	

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F 812	Continued From page 26 During an interview with the Dietary Manager on 6/1/22 at 11:50 AM she was unaware the pasta salad was too warm. She added the pasta salad should have been prepared the previous day so it would be properly cooled. A review of the recipe for the pasta salad provided by the Dietary Manager on 6/2/22 at 3:30 PM read to serve the pasta salad chilled. The critical control point read, "Hold or serve cold food at or below 40 degrees Fahrenheit." During an interview with the Administrator on 5/2/22 at 4:30 PM she indicated she was aware of the food safety concerns. She did not provide any additional information.	F 812	" Dietary Safe Food Temps " Safe Food Handling and Storage This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Dietary staff will monitor proper food storage and safe food temps in the kitchen throughout their shift and sign off on the Dating and Temp Log at the end of each shift. The Dietary Service Director will complete QA Kitchen Inspections weekly to monitor proper food storage and food temperatures on cold foods. The Administrator with complete QA Kitchen Inspections to monitor proper food storage weekly. 4. Quality Assurance monitoring procedure. The Dietary Service Manager will monitor procedures for proper food storage daily x 2 weeks and weekly x 3 months using the Dietary QA Audit which will include inspection of the kitchen and reviewing the Dating Log twice a day. The administrator will complete the QA Kitchen Inspection Form, which will include walking through the kitchen with the Dietary Service Manager, weekly x 3	

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F 812	Continued From page 27	F 812	weeks and monthly x 3. Reports will be presented to the weekly Quality Assurance committee by the Dietary Director to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	