| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345515 | A. BUILDING _____ B. WING _____ | C 01/26/2023 |

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| PRUITTHEALTH-TOWN CENTER | 6300 ROBERTA ROAD HARRISBURG, NC 28075 |

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| E 000 | Initial Comments<br><br>An uannounced recertification survey was conducted 1/23/2023 to 1/26/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9G5M11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted 1/23/2023 to 1/26/2023. 13 of the 13 allegations were not substantiated. Intake Numbers: NC00186862, NC00186882, NC00195413, NC00195722 and NC00190970. | F 000 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response. | F 565 | | 2/23/23 |

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

Electronically Signed | 02/16/2023

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| F 565 | Continued From page 1<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on review of Resident Council Meeting Minutes, resident and staff interviews, the facility failed to resolve repeated concerns voiced at Resident Council meetings regarding call lights not being answered timely and cold coffee being served for 3 of 6 months (10/27/22, 11/30/22 and 1/4/23) reviewed for Resident Council.<br><br>Findings Included:<br><br>A record review of the 10/27/22 Resident Council minutes revealed the following concerns:<br>a. Call lights were being turned off and staff stating they would come back, and they would not come back.<br>The response from nursing was that a nursing staff huddle had been completed to address call lights.<br><br>A record review of the 11/30/22 Resident Council minutes revealed the following concerns:<br>a. Breakfast and Coffee was cold when received by residents.<br>The response from dietary was the dietary department transfers the food cart immediately to | F 565 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>"Resident #34 and #42 were affected, education provided to all staff. On 1/27/2023 the Administrator (or designee) ensured that all coffee distributed to resident□s were hot. On 1/27/2023 the Director of Health Services (or designee) ensured that all call lights were answered within a reasonable timeframe of 15 minutes or less.<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient;<br><br>"All residents have the potential to be affected. On 1/30/2023 the Administrator (and designee) reviewed the October, November, December, and January□s Resident Council meeting minutes to determine that issues identified during | |

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| F 565 | Continued From page 2<br>the hall once it is full. Insulated serve ware was being used to retrain heat. The temperatures are checked on the line and the food is hot when it leaves the kitchen. Dietary will discuss the distribution of trays to the residents with the Director of Nursing.<br><br>b. Call bells were not answered timely on the 3-11 PM weekly shift and all shifts on weekends. Call lights were being turned off by the Nurse and stating the Nurse Aide (NA) will come and the NA would not come back to the resident room.<br>The response form from Nursing was a staff meeting was held to discuss resident council concerns.<br><br>A record review of the Resident Council minutes for 1/4/23 revealed the following concerns:<br>a. Coffee temperatures were not resolved, but residents had felt that it had improved.<br>b. Call light response time had improved from the last meeting in November 2022 but not resolved.<br>The response from nursing was an in-service was held with staff.<br><br>A Resident Council meeting was held on 1/25/23 at 1:30 PM. Two out of ten residents (#34 and #42) expressed that staff do not respond to their call light timely and at times, they had to wait close to an hour, NAs would come and turn off the call light and say they would come back, and they do not. The Resident Council President stated that she felt call light response was improving but wait times can vary from 15 minutes, 30 minutes or longer with another resident (#26) agreeing with the Resident Council President and stated the staff are working as hard as they can. | F 565 | those meetings have been addressed.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>"On 1/30/2023 the Administrator educated the interdisciplinary team which included: Director of Health Services, Activities Director, and Social Services Director on the grievance/concern policy specific to responses based on concerns brought up during Resident Council meetings. The dietary and nursing staff was educated on 1/30/2023 by the Director of Health services (or designee) about the timely distribution of coffee. The entire facility staff was educated on 2/16/2023 by the Administrator (or designee) about the adequate response time to call lights. All employees not educated by 2/17/2023 will be removed from the schedule until education is completed. This education will be added to orientation for all new employee hires.<br><br>"After the monthly Resident Council meeting the Activities Director will immediately notify the Administrator and/or the Director of Health Services of resident concerns to be followed up on and resolved within a reasonable timeframe. This will occur monthly until three (3) months of sustained compliance.<br><br>"Department managers will observe call light response time four (4) times weekly for three (3) weeks, three (3) times weekly | |

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| F 565 | Continued From page 3<br><br>Seven out of ten residents stated their coffee was still cold. Residents expressed it had gotten to a point where it was warm but now it had gone back to being cold, and they did not know what they could do about it.<br><br>An interview was completed with the Dietary Manager (DM) on 1/26/22 at 10:25 AM who stated that they put the food out on the line as hot as it can be but stated the difficulty may be with getting the trays out. The DM stated the coffee is piping hot when it gets poured into carafes and did not know how it could get any hotter. The DM explained that the NA would pour the coffee from the carafe into the cups and put it on the tray and said getting the trays quicker to the residents may need to be the focus but that the NA's are working as hard as they can.<br><br>An interview was completed with the Activities Director on 1/26/23 at 11:20 AM who stated the residents had expressed the cold coffee had improved somewhat in January but was not resolved. The AD expressed that although nursing in-services had been done regarding call light response, it was still an on-going issue with some improvement noted in January by the residents.<br><br>An interview was completed with NA #1 On 1/26/23 at 1:30 PM who stated that she had heard complaints from residents that the coffee was not hot, NA #1 would then go into the kitchen and fill their cup from the large coffee pot and the resident was satisfied.<br><br>An interview was completed with the Administrator on 1/26/23 at 2:00 PM who stated | F 565 | for three (3) weeks, two (2) times weekly for three (3) weeks, and then weekly for three (3) weeks. Department managers will monitor for appropriate temperature for coffee four (4) times weekly for three (3) weeks, three (3) times weekly for three (3) weeks, (2) times weekly for three (3) weeks, and then weekly for three (3) weeks.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br><br>"The Administrator will present the analysis of the Resident Council Meeting Concerns at the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed.<br><br>"The Administrator will present the analysis of the call bell response review to the Resident Council Meeting Concerns at the Quality Assurance and Performance Improvement Committee monthly for review and revision as needed.<br><br>Include dates when corrective action will be completed.<br><br>"Date of compliance will be on 2/23/2023. | |

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| F 565 | Continued From page 4<br>that in response to the cold coffee if the coffee had been sitting for a period of time it will cool and we would be more than happy to re-heat the coffee for the resident. The Administrator stated that related to call lights, we should meet the expectation of the residents upon answering the call light. | F 565 | | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(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-<br>(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;<br>(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<br>(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.<br><br>§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 covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(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 | F 582 | | 2/23/23 |

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| F 582 | Continued From page 5<br>reasonably possible.<br>(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.<br>(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.<br>(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.<br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to issue the correct form; Skilled Nursing Facility-Advanced Beneficiary Notice (SNF-ABN CMS-10055) to 2 of 3 residents reviewed for Beneficiary Protection Notification (Resident #1 and Resident #9).<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 11-29-22 with a diagnosis of hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side.<br>Resident #1 began Medicare Part A skilled | F 582 | Identification of Resident #1 and #9 were affected by this.<br><br>"Residents #1 and #9 were issued the ABN R-131 but as of 1/27/2023 the facility is utilizing the correct ABN CMS-10055 form.<br><br>Identification of other residents affected by the practice.<br><br>"On 1/27/2023 a 100% audit of the last 30 days of discharge was conducted by the Social Services Director to identify all residents that were affected by the use of | |

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| F 582 | Continued From page 6<br>services on 11/29/22. The last covered day of Medicare Part A service was 1/11/23. The facility provider initiated the discharge from Medicare Part A services when benefit days were not exhausted and issued a CMS-R-131 form and not a SNF-ABN CMS-10055 form. Resident #1 remained in the facility.<br><br>Resident #9 was admitted to the facility on 11-18-22 with a diagnosis of spondylosis lumbosacral region (spinal osteoarthritis). Resident #9 began Medicare Part A skilled services on 11/18/22. The last covered day of Medicare Part A service was 12/22/22. The facility provider initiated the discharge from Medicare Part A services when benefit days were not exhausted and issued a CMS-R-131 form and not a SNF-ABN CMS-10055 form. Resident #9 remained in the facility.<br><br>A review of the SNF Beneficiary Protection Notification Review form (CMS-20052) provided by the facility revealed a SNF-ABN CMS-10055 was checked yes as being provided to Resident #1 and Resident #9.<br><br>An interview with the Social Worker (SW) on 1/26/23 at 10:03 AM revealed that she issues the forms but receives the information from the Minimum Data Set (MDS) department. The SW stated she went back and looked at the forms and discovered the facility had been issuing the CMS-R-131 form for the last couple of years and would start to use the correct form.<br><br>An interview with the Administrator on 1/26/23 at 2:00 PM revealed that it was her expectation that the facility would be utilizing the correct form. | F 582 | the incorrect form issued. The facility began using the correct ABN CMS-10055 form on 1/27/2023.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:<br><br>"The Administrator educated the Social Services Director on the regulatory requirement of issuing the proper Skilled Nursing Facility-Advanced Beneficiary Notice ABN CMS-10055 form on 1/27/2023. This education included the utilization of the ABN CMS-10055 form for residents who remain in the facility or discharged after Medicare A services ended who require an ABN be given.<br><br>"The Administrator (or designee) of the facility will review the Medicare Part A discharge binder weekly and validate that the correct ABN form has been provided to those residents whose Medicare Part A services have ended. A weekly audit of five (5) times a week for three (3) weeks, four (4) times a week for three (3) weeks, three (3) times a week for 3 weeks, and then weekly for three (3) weeks will be completed.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br><br>"The Administrator (or designee) will present the analysis of the utilization of the ABN CMS-10055 form to the Quality | |

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| F 582 | Continued From page 7 | F 582 | Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.<br><br>Include dates when corrective action will be completed.<br><br>"Date of compliance will be 2/23/2023. | |
| F 641 SS=B | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff and resident interview the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 4 residents reviewed for MDS accuracy. Residents # 30 and # 44 were not coded for Level ll Preadmission Screening and Resident Review (PASRR). Resident # 206 was not accurately coded for anticoagulant therapy.<br><br>Findings included:<br><br>1.Resident # 30 was readmitted to the facility on 12/06/21 with diagnoses that included anxiety, depression and bipolar disorder.<br><br>A review of a comprehensive annual MDS assessment dated 11/07/22 revealed Resident # 30 was not coded for PASRR Level ll at section A 1500 for Level ll PASRR screening and Resident # 30 was not coded at section A 1510 for Level ll PASRR conditions as required by the RAI manual | F 641 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:<br><br>•The Case Mix Director and/or Case Mix Coordinator competed the MDS corrections or residents #206, #30, and #44 on 1/27/2023.<br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>•The MDS Nurse(s) and Director of Health Services will complete an audit of MDS assessments, reviewing the areas of anticoagulation, Level 2 preadmission screening and resident review (PASRR) that were completed and submitted within the last thirty (30) days. Audit will be completed to identify inaccurately coded | 2/23/23 |

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| F 641 | Continued From page 8<br>(Resident Assessment Manual).<br><br>A letter dated 07/14/22 to the facility from the North Carolina Department Of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed Resident # 30 had been determined to require a Level ll PASRR.<br><br>On 01/26/23 at 9:13 AM an interview was conducted with Case Mix Nurse #2. Case Mix Nurse #2 stated that it was likely an over site that the PASRR Level ll for Resident # 30 was not coded on the most recent MDS assessment.<br><br>The facility administrator was interviewed on 01/26/23 at 11:44 AM and she stated that it was the responsibility of the Case Mix Nurses to accurately code Level ll PASRR status on comprehensive MDS assessments as directed by the RAI manual.<br><br>2. Resident # 44 was admitted to the facility on 10/19/22 with diagnoses that included anxiety, bipolar disorder and psychotic disorder.<br><br>Review of a comprehensive MDS assessment dated 10/24/22 revealed Resident # 44 was not coded for PASRR Level ll at section A 1500 for Level ll PASRR screening and Resident # 30 was not coded at section A 1510 for Level ll PASRR conditions as required by the RAI manual (Resident Assessment Manual).<br><br>A letter dated 11/04/22 to the facility from the North Carolina Department Of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed Resident # 44 had been | F 641 | assessments and issues identified will be corrected and MDS assessments will be resubmitted by 2/1/2023.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>•Facility MDS nurse(s)and Social Services Director will be re-educated by the Regional MDS nurse (or designee) on MDS assessment care areas pertaining to anticoagulation and PASSR Level 2. The Director of Health Services will re-educate the MDS nurses regarding the significant of anticoagulant medications to resident and their plan of care. Residents admitted with or started on any anticoagulants will be discussed 5 days weekly during interdisciplinary meeting, which is on-going. This will also be discussed with any new hires to this department. Education will be completed by 2/23/2023.<br><br>•The Administrator, MDS nurse(s), and Regional MDS Nurse will complete an audit of MDS Assessment care areas of anticoagulation and Level 2 Preadmission Screening and Resident Review four (4) times weekly for three (3) weeks, three (3) times weekly for three (3) weeks, two (2) times weekly for three (3) weeks, and then weekly for three (3) weeks to ensure accuracy. The facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality | |

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| F 641 | Continued From page 9<br>determined to require a Level II PASRR.<br><br>On 01/26/23 at 9:13 AM an interview conducted with Case Mix Nurse # 2 revealed she was not aware that Resident # 44 had received a PASRR Level II status on 11/04/23. Case Mix Nurse #2 revealed prior to completion of the comprehensive MDS admission assessment dated 10/24/22 she was not aware of a Level II PASRR status for Resident # 44 or aware that a PASRR Level II status was pending for Resident # 44.<br><br>The facility Administrator was interviewed on 01/26/23 at 11:44 AM and she stated that it was the responsibility of the Case Mix Nurses to accurately code Level II PASRR status on comprehensive MDS assessments as directed by the RAI manual.<br><br>3. Resident #206 was admitted to the facility on 1/11/2023 with diagnose of a leg fracture.<br><br>An admission Minimum Data Set (MDS) assessment dated 1/16/2023 indicated Resident #206 had not received any anticoagulant medications.<br><br>Review of Resident #206's Physician's Orders revealed an order for Enoxaparin (an anticoagulant medication) 40 milligrams by subcutaneous injection every 12 hours for prophylaxis to prevent deep vein thrombosis which was written on 1/11/2023.<br><br>Resident #206's Medication Administration Record for 1/2023 was reviewed and indicated she received Enoxaparin 40 milligrams by | F 641 | Assurance Performance Improvement Committee. Data will be brought by Administrator to review in Quality Assurance Performance Improvement meetings and changes will be made to the plan as necessary to maintain compliance with comprehensive assessments and timing.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br><br>•The Administrator will present the analysis of the MDS Assessment care areas of anticoagulation and Level 2 Preadmission Screening and Resident review to the Quality Assurance Performance and Performance Improvement meetings monthly until three months of sustained compliance is maintained then quarterly thereafter.<br><br>Include dates when corrective action will be completed.<br><br>• Date of compliance will be 2/23/2023. | |

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| F 641 | Continued From page 10<br>subcutaneous injection every 12 hours since she was admitted to the facility on 1/11/2023.<br><br>During an interview with Minimum Data Set (MDS) Nurse #2 on 1/26/2023 at 9:49 am she stated she completed Resident #206's admission MDS and she overlooked that Resident #206 received Enoxaparin (an anticoagulant medication) and did not code the MDS correctly. MDS Nurse #2 reviewed Resident #206's Medication Administration Record for 1/2023 and stated the medication was administered 1/11/2023 to 1/25/2023.<br><br>Administrator #1 was interviewed on 1/26/2023 at 1:17 pm and stated the MDS Nurse should have assessed Resident #206 for anticoagulant medication use and coded the admission MDS assessment correctly. | F 641 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(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:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census. | F 732 | | 2/23/23 |

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| F 732 | Continued From page 11<br>§483.35(g)(2) Posting requirements.<br>(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.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and Director of Nursing interview, the facility failed to post accurate staffing information for licensed and unlicensed nursing staff for 5 of 5 posted daily staffing forms reviewed.<br><br>Findings included:<br><br>Daily staffing forms for 7/16/2022, 9/22/2022, 10/6/2022, 12/31/2022 and 1/17/2023 were reviewed and revealed the following were not accurate on 5 of 5 dates:<br><br>a. The nursing schedule for 7/16/2022 was reviewed:<br>* The schedule had 2.5 nursing assistants (NAs) to work the day shift (7:00 AM to 3:00 PM). | F 732 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>"No residents were affected by deficient practice<br><br>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>"This did not have the potential to affect other residents.<br><br>Address what measures will be put into place or systemic changes made to | |

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| F 732 | Continued From page 12<br>The posted daily staffing sheet indicated 3 NAs were providing care in the facility.<br>* The schedule for afternoon shift (3:00 PM to 11:00 PM) had 1 Registered Nurse (RN), 2 Licensed Practical Nurses (LPNs) and 4 NAs scheduled to work. The posted daily staffing sheet indicated 2 RNs, 3 LPNs and 5 NAs were providing care for that shift.<br>* The schedule for night shift (11:00 PM to 7:00 AM) had 1 RN, 1 LPN, and 2 NAs scheduled. The posted daily staffing sheet indicated no RN was providing care, 4 LPN, and no NA were providing care in the facility.<br><br>b. The nursing schedule for 9/22/2022 was reviewed.<br>* The schedule for day shift had 3 LPNs and 3.5 NAs scheduled to work. The posted daily staffing sheet indicated 4 LPNs and 4 NAs were providing care.<br>* The schedule for afternoon shift had 0.5 RN, 2 LPNs scheduled to work. The posted daily staffing sheet indicated 1 RN and 4 LPNs were providing care in the facility.<br>* The schedule for night shift was reviewed and 1 RN, 1 LPN, and 3 NAs were scheduled to work. The posted daily staffing sheet indicated no RN, 2 LPN, and 2 NAs were providing care in the facility.<br><br>c. The nursing schedule for 10/6/2022 was reviewed.<br>* The schedule for afternoon shift had 1.5 RNs, 1.5 LPNs and 4 NAs scheduled to work. The posted daily staffing sheet indicated 3 RNs, 4 LPNs, and 5 NAs were providing care in the facility.<br>* The schedule for night shift had 2 RNs, 1 | F 732 | ensure that the deficient practice will not recur;<br><br>"The Administrator educated the scheduler regarding the Posted Nurse Staffing, including the need for accuracy of posting and updating the posting as changes occur with the schedule and to the facility□s residents census on 1/26/2023.<br><br>"The Scheduler, Director of Health Services, or Nurse Manager will complete a review of the posted nurse staffing daily for accuracy and make changes indicated for five (5) times weekly for three (3) weeks, four (4) times weekly for three (3) weeks, three (3) times weekly for three (3) weeks, then weekly for three (3) weeks or until substantial compliance is achieved and maintained.<br><br>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and<br><br>"The Director of Nursing will present the analysis of the review of the posted nurse staffing daily for accuracy to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.<br><br>Include dates when corrective action will be completed.<br><br>"Date of compliance will be 2/23/2023. | |

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| F 732 | Continued From page 13 | F 732 | | |

LPN, and 2 NAs scheduled to work. The daily posted staffing sheet indicated that 1 RN, 2 LPNs, and 3 NAs were providing care in the facility.

d. The nursing schedule for 12/31/2022 was reviewed.
* The schedule for day shift had 3.5 NAs scheduled to work. The daily posted staffing sheet indicated 4 NAs provided care that shift.
* The schedule for the afternoon shift was reviewed and 0.5 RN, 1.5 LPN, and 3 NAs were scheduled to work. The daily posted staffing sheet indicated 1 RN, 3 LPN, and 5 NAs were providing care during afternoon shift on 12/31/2022.
* The schedule for night shift had 3 NAs scheduled to work. The daily posted staffing sheet indicated 4 NAs were providing care in the facility.

e. The schedule for 1/17/2023 was reviewed.
* The schedule for day shift had 4 NAs scheduled to work. The daily posted staffing sheet indicated no NAs were providing care.
* The schedule for afternoon shift had 1 RN, 2 LPNs, and 5.5 NAs scheduled to work. The daily posted staffing sheet indicated 3 RNs, 3 LPNs and no NAs were providing care that shift.
* The schedule for night shift had 3 NAs scheduled to work. The daily posted staffing sheet indicated 2 NAs were providing care in the facility that shift.

The Director of Nursing (DON) was interviewed on 1/26/2023 at 10:36 AM. The DON reported that she had just started 4 days ago, and the previous DON was not available for interview.

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| F 732 | Continued From page 14<br>The DON explained that she was responsible for scheduling staff and updating the daily posted staffing sheet. The DON reported the staffing sheets had been completed incorrectly. The DON reported the daily posted staffing sheets should accurately reflect the staffing in the facility. | F 732 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to dry 6 of 6 steamer pans before stacking for storage. This had the potential to affect food served to all residents.<br><br>Findings included:<br><br>The kitchen was observed on 1/23/2023 at 9:12 | F 812 | Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br><br>"No residents were affected by deficient practice. | 2/23/23 |

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| F 812 | Continued From page 15<br>AM. A metal shelving unit was noted with stacked steamer pans ready for use. Two medium pans were separated and noted to be wet in between the pans. Two large pans were separated and noted to be wet in between the pans, and two small pans were separated and noted to be wet between the pans.<br><br>The dietary manager (DM) was interviewed at the time of the observation. The DM reported the pans should have been air dried completely before being stacked for storage and use. The DM reported he thought kitchen staff may have been in a hurry to put the pans up for storage.<br><br>The DM was interviewed again on 1/25/2023 at 1:02 PM. The DM reported he had talked to the kitchen staff and found that the pans were stacked wet because the staff were rushing to tidy the kitchen.<br>The Administrator was interviewed on 1/26/2023 at 1:27 PM. The Administrator reported the pans should be air-dried before they were stacked for use and storage. | F 812 | Address how the facility will identify other residents having the potential to be affected by the same deficient practice;<br><br>"This had the potential to affect food served to all residents. On 1/26/2023 the six steamer pans were thoroughly washed, and air dried completely before being properly stored and for usage.<br><br>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;<br><br>"Education was provided to the entire dietary staff by the Dietary Manager on 1/23/2023 on the proper dryness and storage of the steamer pans.<br><br>"The Registered Dietician will complete a monthly assessment for three (3) months for sustained compliance. The Dietary Manager will complete an assessment of all steamer pans to ensure compliance with complete air drying requirements and storage five (5) times a week for three (3) weeks, four (4) times weekly for three (3) weeks, three (3) times weekly for three (3) weeks, and then weekly for three (3) weeks.<br><br>Indicate how the facility plans monitor its performance to make sure that solutions are sustained; and<br><br>"The Registered Dietician and/or Certified Dietary Manager will present the analysis of the proper dryness and storage of the | |

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| F 812 | Continued From page 16 | F 812 | steamer pans to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter.<br><br>Include dates when corrective action will be completed.<br><br>"Date of compliance will be 2/23/2023. | |