STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 survey was conducted on 3/6/23 through 3/9/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5N6611.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/6/23 through 3/9/23 Event ID# 5N6611. The following intakes were investigated NC00189677 and NC00188003. 1 of the 2 complaint allegations resulted in deficiencies.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 553		3/30/23

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

Electronically Signed | 03/30/2023

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

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F 553	Continued From page 1 of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility failed to invite a cognitively intact resident to participate in the planning of the resident's care for 1 of 1 resident (Resident #31) reviewed for participation in care plans. The findings included: Resident #31 was admitted to the facility on 3/1/21 with diagnoses that included, in part, hypertension and diabetes. A care plan conference attendance sheet dated 9/25/22 was reviewed and revealed the Minimum Data Set (MDS) nurse and Activities Director signed as having met and reviewed Resident #31's care plan. There was no documented evidence that the resident was invited to attend or participate in the care plan conference. The annual Minimum Data Set assessment dated 12/17/22 revealed Resident #31 had intact cognition.	F 553	Corrective action to be accomplished for the residents found to be affected by the deficient practice: Resident #31 was interviewed by the new MDS coordinator who began work on 2/27/23 to determine what he would like to discuss currently regarding his care. He was informed that he would be included in his care plan meetings but also that he could voice concerns or make requests known at any time for his care. Resident #31 participated in a care plan meeting on 3/15/23 with the MDS coordinator, Activities Director and all three signed the Interdisciplinary Care Plan Conference form. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The MDS nurse met with other residents who are cognitively intact to notify them that they will be included in their care plan	

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F 553	Continued From page 2 During an interview with Resident #31 on 3/06/23 at 11:15 AM, he stated he had not been invited to participate in care plan meetings. He said he would like to be included in the care plan process and added, "I want to know what is going on" with his care. On 3/07/23 at 1:25 PM and 3/8/23 at 10:27 AM, interviews were conducted with the Administrator. She explained that typically, care plan meetings were held on Wednesdays and residents and families were invited to attend. She shared the facility had been without a MDS nurse since December 2022 and there hadn't been an invitation to residents and families to attend care plan meetings. She added a new MDS nurse had been hired and began work on 2/27/23 and the facility would be re-instituting inviting residents and families to care plan meetings.	F 553	meetings and could also have family present as desired. They were also informed that they could voice concerns or make requests known at any time to address care needs. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The MDS coordinator has planned out the April schedule of MDS assessments and care plan meetings. Invitations have been mailed to family members as well as in person notifications to residents. The form SNF 10- Interdisciplinary Care Plan Conference will be utilized with the new MDS coordinator in place to document the Care Plan meeting. When completed on the day of the care plan conference, there will be documentation of those invited and attending the care plan conference. This form also provides a space to record that the resident is invited and attended or if they chose not to participate, as well as any family or responsible party attendance. The MDS Coordinator will complete the schedule for the upcoming month's care plans by the 15th of the current month. The Unit Secretary will send the invitations for the scheduled care plan meetings and provide a copy of the letter to the MDS Coordinator for planning and coordination with attendees. The copy will be placed with the Interdisciplinary Care Plan Conference form. The process will	

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F 553	Continued From page 3	F 553	occur monthly to ensure all residents and responsible party/family members are aware and can participate as they choose. Indicate how the facility will monitor our performance to make sure that solutions are sustained: A record of the resident care plan conference and invitations as well as attendance will completed monthly and monitored for compliance. Performance will be monitored by the MDS nurse and reported monthly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue monthly for 1 year to make sure the solution is maintained.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interviews the facility failed to accommodate the needs of 1 of 1 residents (resident #33) by not providing the resident a shower gurney or chair to fit the resident resulting in the resident receiving only bed baths for the last few months. Findings included:	F 558	Corrective action to be accomplished for the residents found to be affected by the deficient practice: Resident #33 was assessed by the Physical Therapist to provide feedback on appropriateness and safety with the use of the facility bariatric shower chair. The physical therapist completed the	3/30/23

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F 558	Continued From page 4 Resident #33 was admitted to the facility on 5/4/22 with multiple diagnoses to include history of stroke, osteoarthritis, atrial fibrillation, and coronary artery disease. The quarterly Minimum Data Set (MDS) dated 11/7/22 revealed that the resident was cognitively intact. Resident #33 was coded as total dependence with 2 staff members assisting for transfers. The latest weight documented for Resident #33 was 326 pounds on 2/14/23. During an interview with Resident #33 on 3/7/23, he stated that he had only been getting bed baths for several months and that he preferred to have a shower. He stated that the facility didn't have the equipment needed to get him out of bed, onto the shower gurney, and down to the shower room. He added that they tried to get him on the gurney again the other day but it came up on two wheels and the girls were afraid he would fall so they put him back to bed. During an interview with Nurse Aide #1 on 3/8/23, she stated that she and another aide did attempt to get Resident #33 out of bed and onto the shower gurney a couple days ago. She stated that, she was not sure what the weight limit was for the gurney. She stated the gurney came up on two wheels but did not turn over when they placed him on there. She added that she and the other aide decided to put him back in bed for safety reasons which they did without any further incident. She added that Resident #33 had been receiving bed baths for at least 2 months. She was unsure of the exact time period. During an interview with Nurse #1 on 3/8/23, she	F 558	assessment and determined the shower chair could safely be used. The resident received his shower as planned on 3/9/2023. He will continue to use the shower chair as requested. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit for all other residents who are cognitively intact to request a shower was completed by the MDS nurse. No other residents were identified as not receiving a bath or shower per their request. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: The MDS nurse will monitor for bathing preference and accommodation at a minimum with each resident care plan conference. Any resident making a request for change at any time will be addressed by staff receiving the request and communicated to the nurse and MDS nurse for follow up and care planning. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance will be monitored monthly for 1 year and reported monthly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue monthly for 1	

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F 558	Continued From page 5 stated that Resident #33 had gained about 100 pounds over the last year due to poor diet and sedentary lifestyle. She stated he usually only got out of bed for outside doctor appointments and the staff would use a lift. Nurse #1 stated that she was made aware Resident #33 was only receiving bed baths when Nurse Aide #1 advised her of the near accident the prior day. She stated that the resident had gained a lot of weight over the last year and agreed that it was probably unsafe to try to transport him on the shower gurney. She added that they did have a shower chair but she was unsure if that would be suitable for him or not. During an interview with the Administrator on 3/9/23, she stated she was unaware that Resident #33 was only receiving bed baths and that he had stated that the facility did not have the equipment that allowed him to use the shower. She stated the weight limit for the shower gurney was 166 kilograms/326 pounds. She stated that they had a shower chair that may have worked for him and added that she planned on involving physical therapy to assess for safety. She stated that every resident had the right to receive a shower based on their preferences.	F 558	year to make sure the solution is maintained.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument.	F 636		3/30/23

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F 636	Continued From page 6	F 636		

A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i)

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F 636	Continued From page 7 through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to complete an annual Minimum Data Set (MDS) comprehensive assessment within 366 days of the previous comprehensive assessment for 1 of 2 residents (Resident #18) reviewed for timely completion of annual MDS assessments. The findings included: Resident #18 was admitted to the facility on 12/30/21 with diagnoses that included, in part, diabetes, congestive heart failure and dementia. The admission MDS assessment with an assessment reference date of 1/5/22 was reviewed and revealed the assessment was signed as completed on 1/9/22. The most recent MDS assessment in the medical record was a quarterly review, completed on 10/3/22. Further review of the medical record demonstrated an annual MDS assessment had not been completed. An interview was completed with the	F 636	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The NC RAI Education coordinator was contacted regarding the proper way to record and reflect the data recorded on paper but not entered into the AHT system at the appropriate time for Resident #18. This data was entered into the AHT system and reflected as closing on 3/30/2023 for the point in time of 12/31/2022 and reflected with closing signature on the paper chart. The MDS nurse is completing the current assessment for Resident #18 with an ARD of 4/1/2023 to bring the resident record current. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents was completed to determine if any other residents were missing an annual comprehensive	

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F 636	Continued From page 8 Administrator on 3/8/23 at 2:48 PM. She stated the most recent MDS assessment completed on Resident #18 was a quarterly dated 10/3/22. She explained the resident's next assessment should have been an annual assessment dated 12/31/22 and "it just got missed." The Administrator noticed the assessment had not been completed when she was asked to provide the most recent MDS assessment. She shared the facility had been without a full time MDS nurse since December 2022 and MDS assessments fell behind schedule. The Administrator said she helped with MDS assessments, and there was a part time employee and another nurse who completed MDS assessments as well.	F 636	assessment. 5 residents had assessments completed but not entered into AHT system and submitted. These assessments for February, 2023 were submitted on 3/14/23 and 3/18/23. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: All annual assessments are now completed and submitted. The MDS nurse has communicated the calendar to the interdisciplinary team for planning to complete the timely assessments as well as attending the care plan meetings. The MDS nurse will print monthly calendars of assessments due for the upcoming month and communicate them to the interdisciplinary team by the 15th of the current month. The schedule will be pulled from the AHT system and audited for accuracy on a monthly basis. This process will be repeated monthly concurrently with the scheduling of care plan meetings. The new MDS nurse is completing education regarding MDS completion per the Myers and Stauffer education, meeting with interdisciplinary care plan team members as well as education by the State RAI coordinator. The form SNF 10- Interdisciplinary Care Plan Conference will be utilized with the new MDS coordinator in place to document the Care Plan meeting. When	

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F 636	Continued From page 9	F 636	completed on the day of the care plan conference, there will be documentation of those invited and attending the care plan conference. This form also provides a space to record that the resident is invited and attended or if they chose not to participate, as well as any family or responsible party attendance. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance will be monitored by the MDS nurse and reported monthly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue monthly for 1 year to make sure the solution is maintained.	
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the Assessment Reference Date (ARD) of the previous MDS assessment for 4 of 10 residents (Residents #9, #37, #14 and #2) reviewed for timely completion of MDS assessments.	F 638	Corrective action to be accomplished for the residents found to be affected by the deficient practice: Quarterly review assessments were completed for Residents #9, #37 and #14 but had not been entered in the AHT system for submission. These were entered and submitted on 3/30/23/ The	3/30/23

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F 638	Continued From page 10 Findings included: 1. Resident #9 was admitted to the facility on 7/24/17. A review of the Minimum Data Set (MDS) assessments for Resident #9 revealed the last assessment completed was a quarterly assessment completed on 10/12/22. No other MDS assessments had been completed since 10/12/22. 2. Resident #37 was admitted to the facility on 6/30/22. A review of the Minimum Data Set (MDS) assessments for Resident #37 revealed the last assessment completed was a quarterly assessment completed on 10/17/22. No other MDS assessments had been completed since 10/17/22. 3. Resident #14 was admitted to the facility on 8/11/20. A review of the Minimum Data Set (MDS) assessments for Resident #14 revealed the last assessment completed was a quarterly assessment completed on 10/13/22. No other MDS assessments had been completed since 10/13/22. 4. Resident #2 was admitted to the facility on 6/1/16. A review of the Minimum Data Set (MDS) assessments for Resident #37 revealed the last assessment completed was a quarterly assessment completed on 10/30/22. No other MDS assessments had been completed since 10/30/22. During an interview with the Administrator on 3/9/23, she stated that the previous MDS nurse left in November 2022 and she was aware that there were several assessments that were overdue. She stated that they had just hired a	F 638	quarterly assessment for resident #2 had been completed and submitted on 3/4/23 as late. These residents are scheduled for their next quarterly assessments and are on schedule for timely completion of their assessments. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all quarterly assessments was completed. Completion of the assessments that were overdue have been recorded and submitted. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: All quarterly assessments are scheduled and the MDS nurse has communicated the calendar to the interdisciplinary team for planning to complete the timely assessments as well as attending the care plan meetings. The form SNF 10- Interdisciplinary Care Plan Conference will be utilized with the new MDS coordinator in place to document the Care Plan meeting. When completed on the day of the care plan conference, there will be documentation of those invited and attending the care plan conference. This form also provides a space to record that the resident is invited and attended or if they chose not to participate, as well as any family or	

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F 638	Continued From page 11 new MDS nurse and it was her expectation that they would complete all the assessments that were overdue first and then making sure they complete the required MDS assessments in a timely manner going forward.	F 638	responsible party attendance. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance will be monitored by the MDS nurse and reported monthly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue monthly for 1 year to make sure the solution is maintained.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		3/31/23

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	345166	A. BUILDING _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

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F 732	Continued From page 12 (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the daily nursing staff postings, the facility's daily posting failed to include the number of registered nurses (RNs) or licensed practical nurses (LPNs) for 30 of 30 days; failed to include the census for 18 of 30 days; and failed to include nurses and certified nursing assistants (CNAs) actual hours worked for 4 of 30 days. Additionally, the facility failed to complete the daily posting for 10 of 30 days. Findings included: 1. The daily nursing staff postings were reviewed for February 5-March 6, 2023. The postings indicated the name of the nurse who worked each shift but did not include a designation of RN or LPN. On 3/8/23 at 2:38 PM an interview was completed with the Administrator. She explained the third shift nurse completed the daily posting for the entire day, which included all three shifts. She said the posting did not include an option that	F 732	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The form for posting of Nurse Staffing information was updated to have all required data elements and put in place for use on 3/9/23. The positing reflects the nurse as RN or LPN, CNA and the hours for each. In addition, the shift to shift census will be recorded. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The form for posting of Nurse Staffing information was updated to have all required data elements and put in place for use on 3/9/23. The positing reflects the nurse as RN or LPN, CNA and the hours for each. In addition, the shift to shift census will be recorded.	

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F 732	Continued From page 13 designated whether the nurse scheduled to work was a RN or LPN. 2. The daily nursing staff postings were reviewed for February 5-March 6, 2023. The postings did not include the facility census on the following dates: 2/5/23-2/6/23, 2/9/23-2/10/23, 2/12/23, 2/14/23, 2/18/23, 2/23/23-2/24/23, 2/28/23-3/1/23, and 3/5/23 (7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts); 2/7/23-2/8/23, 2/13/23, 2/15/23, 3/3/23 and 3/6/23 (3:00 PM-11:00 PM shift). On 3/8/23 at 2:38 PM an interview was completed with the Administrator. She explained the third shift nurse completed the daily posting for the entire day, which included all three shifts. She said the facility needed to designate a charge nurse who completed/updated the daily posting on the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts so that it accurately reflected changes in the census and any staffing changes such as call outs or replacements. 3. The daily nursing staff postings were reviewed for February 5-March 6, 2023. The postings did not include actual hours worked for nurses and CNAs on the following dates: 2/7/23-2/8/23 and 3/3/23 (3:00-11:00 PM shift), and 2/12/23 (7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts). On 3/8/23 at 2:38 PM an interview was completed with the Administrator. She explained the third shift nurse completed the daily posting for the entire day, which included all three shifts. She said the facility needed to designate a charge nurse who completed/updated the daily posting on the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts so that it accurately reflected changes in the census and any staffing changes such as call	F 732	Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: All charge nurses were informed via memo regarding the completion of census and staffing for the daily postings. The completion will be monitored by the secretary and MDS nurse and addressed with charge nurses if all data elements are not recorded. The forms will be placed in the binder provided as each new daily form is initiated. The binder will be monitored biweekly for presence of daily records as well as completion. Initial 3 weeks were completed daily. The Completion of the daily posting has been added to the orientation checklist for charge nurses. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance will be monitored by the MDS nurse, secretary or designee and reported monthly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue monthly for 1 year to make sure the solution is maintained.	

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F 732	Continued From page 14 outs or replacements. 4. The daily nursing staff postings were reviewed for February 5-March 6, 2023. No posting was completed for the following dates: 2/16/23-2/17/23, 2/19/23, 2/21/23-2/22/23, 2/25/23-2/27/23, 3/2/23 and 3/4/23. On 3/8/23 at 2:38 PM an interview was completed with the Administrator. She explained the third shift nurse completed the daily posting for the entire day, which included all three shifts. She said the facility needed to designate a charge nurse who completed/updated the daily posting on the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts so that it accurately reflected changes in the census and any staffing changes such as call outs or replacements.	F 732		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		3/15/23

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F 812	Continued From page 15 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of expired nutritional supplements and failed to dispose of expired individually packaged cartons of juice from 1 of 1 nourishment room. The findings included: Observations of the nourishment room on 3/7/23 at 11:42 AM and on 3/8/23 at 10:40 AM revealed the following: a. Nine (2.5 ounce) bottles of a protein supplement on the dry storage rack with a use by date of 1/5/23. b. Six (2.5 ounce) bottles of a protein supplement in the refrigerator with a use by date of 1/5/23. c. Ten (4 ounce) containers of prune juice in the freezer with a best by date of 1/24/23. Dietary Aide #1 was interviewed on 3/8/23 at 10:43 AM, while she stocked the nourishment room. She explained the dietary department checked for expiration dates prior to stocking food and drink items in the nourishment room but had not checked dates for expiration after food and drink items were placed in the nourishment room. During an interview with the Unit Secretary on 3/8/23 at 10:46 AM, she stated dietary staff came to the unit daily and stocked the nourishment room and refrigerator. She thought dietary staff	F 812	Corrective action to be accomplished for the residents found to be affected by the deficient practice: The food refrigerator as well as supplemental snack cabinet was checked for out of date nourishments on 3/8/23 to verify remaining nourishments were in date. A policy for Monitoring of Food Expiration Dates was developed and implemented on 3/15/23. A weekly checklist was developed for completion by Dietary staff on 3/15/23 and implemented. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The food refrigerator as well as supplemental snack cabinet was checked for out of date nourishments on 3/8/23 to verify remaining nourishments were in date. A policy for Monitoring of Food Expiration Dates was developed and implemented on 3/15/23. A weekly checklist was developed for completion by Dietary staff on 3/15/23 and implemented. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur: A policy for Monitoring of Food Expiration Dates was developed and implemented	

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F 812	Continued From page 16 checked dates for expiration when they re-stocked the nourishment room. On 3/8/23 at 10:50 AM an interview was conducted with the Administrator. She had recently removed the protein supplements from the nourishment room since they had expired and didn't know why they were back in the dry storage area and refrigerator. She said the dietary department stocked the nourishment room. She added the night shift nursing staff checked the temperature in the refrigerator each night, and after reviewing information with nursing staff, verified that no one had consistently checked for expired foods in the nourishment room.	F 812	on 3/15/23. A weekly checklist was developed for completion by Dietary staff on 3/15/23 and implemented. All dietary staff responsible for delivering and monitoring expiration dates was educated regarding the policy and checklist completion. Indicate how the facility will monitor our performance to make sure that solutions are sustained: Performance will be monitored by the dietary manager and reported monthly to the Nursing Home QAPI meeting as well as the monthly Housewide QAPI meeting. This reporting will continue monthly for 1 year to make sure the solution is maintained.	