STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING ______ B. WING ______	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	**2041 WILLOW ROAD GREENSBORO, NC 27406**

(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 01/21/24 through 01/24/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # G7GT11	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 01/21/24 through 01/24/24. Event ID# G7GT11. The following intakes were investigated: NC00210479, NC00209413, NC00208261 , NC00206831, NC00212101, and NC00212303. 21 of the 21 complaint allegations did not result in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (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. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (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. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		2/21/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 02/15/2024

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 565	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §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. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with residents and staff, the facility failed to resolve group concerns (new and repeat concerns) reported during Resident Council meetings for 6 of 6 consecutive months (June 2023 to December 2023). The findings included: Review of the monthly Resident Council meeting minutes dated 6/27/23 included concerns that there was not enough variety in meal options, the facility was running out of evening snacks / sandwiches and there were not enough weekend activities. These minutes were recorded by the Activities Director. The minutes did not include the names of residents who had attended the meeting. Review of the monthly Resident Council meeting minutes dated 7/25/23 included a repeat concern	F 565	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F565-Resident/Family Group and Response: 1. Snacks are now provided more frequently throughout the day to ensure residents have snacks and sandwiches when they are requested. The Staff Development Coordinator provided education on 2/15/2024 to nursing staff regarding cell-phone use and noise levels. 2. Current Residents have the potential to be affected by the alleged deficient	

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F 565 Continued From page 2

regarding the facility running out of evening snacks. The minutes did not indicate if concerns were resolved from last meeting. These minutes were recorded by the Activities Director. The minutes did not include the names of residents who had attended the meeting.

Review of the monthly Resident Council meeting minutes dated 8/28/23 included the concern that there was not enough variety in dessert and side options. The minutes did not indicate if concerns were resolved from last meeting. These minutes were recorded by the Activities Director. The minutes did not include the names of residents who had attended the meeting.

Review of the monthly Resident Council meeting minutes dated 9/25/23 included repeat concerns that there was not enough variety of breakfast options and the facility was running low on evening snacks and sandwiches. The minutes did not indicate if concerns were resolved from last meeting. These minutes were recorded by the Activities Director. The minutes did not include the names of residents who had attended the meeting.

Review of the monthly Resident Council meeting minutes dated 10/23/23 included the repeat concern of running out of fresh foods and not having enough condiments. A new concern was reported related to staff utilizing cell phones when working. The minutes did not indicate if concerns were resolved from last meeting. These minutes were recorded by the Activities Director. The minutes did not include the names of residents who had attended the meeting.

Review of the monthly Resident Council meeting

F 565

practice. Resident council minutes for the last 6 months were audited by the administrator to ensure response and resolution has been implemented. Administrator held resident council meeting on 02/2024 to discuss resolution to concerns of snacks, cell phone use, and noise levels mentioned during previous months meetings (07/2023-12/2023).

3. Administrator provided education to leadership team on 2/14/2024 noting response to concerns voiced in resident council meetings was mandatory. Activities director was educated on Activities Policies and Procedures Policy #601, which states she is to provide the administrator with the original minutes of the council meetings along with administrative response to the resident council form for review and signature.

4. The administrator will meet weekly with the resident council current president weekly x4 weeks, biweekly x4 weeks, then monthly x3 months with monthly review of original minutes of meeting along with the administrative response to resident council.

5. The Administrator or designee will report Findings to the QAPI committee monthly for review, evaluation, and further recommendations as indicated.

6. Date of completion 2/21/2024

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F 565 Continued From page 3 F 565

minutes dated 11/27/23 included the repeat concerns regarding providing more food options available for meals and after hour snacks. There were new concerns about nursing staff being too loud and nurse aides giving residents no options for meals to be sent back or replaced. These minutes were recorded by the Activities Director. The minutes did not indicate if concerns were resolved from last meeting.

Review of the monthly Resident Council meeting minutes dated 12/15/23 included the repeat concerns of nurse aides using phones a lot and being loud in the halls. These minutes were recorded by the Activities Director. The minutes did not indicate if concerns were resolved from last meeting. The minutes did not include the names of residents who had attended the meeting.

A Resident Council meeting was conducted on 1/22/24 from 2:50 - 3:30 PM. The meeting was attended by 10 members of the Resident Council. The residents reported that they had repeat concerns over the past several months that included not having adequate snacks and sandwiches, variety in food, nurse aides were loud in the hallway and nursing staff were on the phone during their shift. The meeting attendees stated that these concerns had not been resolved. When asked what the facility ' s response was to them regarding these concerns the group indicated they had not received any response to these concerns.

An interview was conducted with the Activities Director on 1/24/24 at 10:00 AM. She confirmed there were multiple repeat issues that came up frequently in the Resident Council meetings. She

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F 565	Continued From page 4 explained that after each meeting she reported the issues verbally during the next day's morning meeting and assumed the respective department would resolve the issue. The Activities Director stated that at the next Resident Council meeting she informed the resident council that she had reported the issue during the morning meeting. The Activities Director indicated she had not filed any grievance form related to the resident council group grievances. She further indicated she was not aware how the facility resolved the group concerns. The Activity Director stated that the meeting was usually conducted after a bingo activity and the residents who wished to attend the meeting would stay back in the room. She did not document the names of the residents who attended the meeting. An interview was conducted with the Administrator on 1/24/24 at 10:30 AM. He indicated the facility had identified areas that needed improvement regarding Resident Council meeting during their pre survey evaluation. A process improvement project (PIP) started on 1/22/24. The identified area was regarding follow up to concerns voiced during Resident Council meeting. He stated the plan of corrections were in process where the activity staff should inform him about any group concerns after the meeting. The Grievance Forms should be filled out for any group grievances and given to the respective department so that a satisfactory resolution was reached within an appropriate times. The Administrator indicated he was the Grievance Officer and would start paying more attention to the group grievance resolutions. The Administrator stated that the Resident Council minutes should indicate the resident's names who attended the meeting and document if the old	F 565		

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F 565	Continued From page 5 grievances were resolved to the satisfaction of the council and any new concerns that were indicated in the meeting. He indicated that his expectation was for all issues/concerns discussed at the Resident Council meetings to be reviewed and/or investigated as needed with follow-up being provided to the Resident Council members.	F 565		
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.	F 690		2/21/24

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F 690	Continued From page 6 §483.25(e)(3) For a resident with fecal 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 record review and staff interview, the facility failed to obtain orders related to an indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheter (Resident # 95). Findings Included: Resident #95 was admitted on 12/11/23 with diagnoses that included Congestive heart failure, Acute respiratory failure, Diabetes mellitus Type 2, and Benign prostatic hyperplasia with lower urinary tract symptoms. Review of the resident's FL2 (a form that describes resident's medical condition and the amount of care needed when placed in the facility) revealed the resident had an indwelling urinary catheter. Review of the admission nursing note dated 12/11/23 revealed the resident was admitted to the facility with an indwelling urinary catheter. Note also read in part "Voiding trial while inpatient." Review of the Nurse Practitioner (NP) note date 12/12/23 indicated the resident had urinary retention and had difficulty when indwelling catheter was removed. The indwelling catheter was replaced on 12/3/23 prior to admission due	F 690	F690-Bowel/Bladder Incontinence, Catheter, UTI 1. Resident #95 failed to have orders implemented for indwelling urinary catheter 2.Current residents are at risk. Resident # 95 has had orders updated to include the use of foley catheter . 3. Chart review of current residents with foley catheters performed by Director of Nursing on 1/22/24 to ensure that current residents with indwelling catheter have orders in place. Current licensed nurses will be educated by the Staff Development Coordinator or designee on transcription of indwelling catheter orders and timeliness of entering catheter orders upon admission. Education will be completed by 2/9/24. Licensed nursing staff not receiving education will not be allowed to work until education received. New licensed nursing staff will receive education within the orientation process by the Staff Development Coordinator. 4. Director of Nursing or designee will audit new admission charts within 24 hours to ensure that foley catheter care orders are entered. Audits will occur	

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F 690	Continued From page 7 to obstruction and ongoing retention. Note also indicated the indwelling urinary catheter was present with clear yellow urine. The resident would be followed up by Urologist. The note did not have any order for indwelling urinary catheter. Review of physician's note dated 12/15/23 revealed the resident had urinary retention and had difficulty with indwelling urinary catheter removal. Note indicated the plan was for a Urology follow up for voiding trial. There were no orders for indwelling urinary catheter. Review of the admission Minimum Data Set (MDS) assessment dated 12/18/23 revealed the resident was assessed as severely cognitively impaired. Assessment indicated the resident had an indwelling urinary catheter. Review of the care plan date 12/22/23 revealed resident was care planned for indwelling urinary catheter related to obstructive uropathy. Goal was for the resident to be free from complications related to catheter use. Interventions included changing per physician order, emptying urinary catheter drainage bag as needed and recording the urine output. Maintaining catheter anchored and maintaining catheter privacy bag. Observing signs and symptoms of infection such as dark or cloudy urine or blockage and notify the physician as indicated. Staff should provide catheter care every shift. Review of the physician orders from 12/11/23 to 1/24/24 revealed no orders regarding indwelling urinary catheter. During an interview on 01/24/24 01:16 PM, Nurse #6 stated the resident has an indwelling urinary	F 690	5 times weekly X 4 weeks then 3 times weekly for x 4 weeks, then once weekly X 4 weeks. 5. The Director of Nursing will provide the results of the audits for review at Quarterly Quality Assurance Meeting X 1 for further resolution if needed. 6. Date of completion 2/21/2024	

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F 690	Continued From page 8 catheter and has no issues with his catheter. She further stated the resident was admitted with an indwelling urinary catheter and does not see any orders for the indwelling urinary catheter. During an interview on 1/24/24 at 1:00 PM, the Director of Nursing (DON) stated the resident was admitted to the facility with an indwelling urinary catheter. The resident was admitted from the hospital and a voiding trial was completed at the hospital which he had failed. The DON stated the provider writes the orders for urinary catheter. The orders were missed when the resident was admitted to the facility. The DON indicated the resident does have a care plan for indwelling urinary catheter. The care was also listed for the Nurse Aides on their care tracker so that catheter care could be provided to the resident. On 1/24/24 at 1:30 PM, during an interview, Nurse Practitioner expected the staff to obtain the order for indwelling urinary catheter. During an interview on 1/24/24 at 2:39 PM, the Administrator stated all orders should be in the electronic medical records. The Administrator further stated the physician's orders should be cross-checked and reviewed during clinical meeting. The Administrator indicated there were multiple steps to ensure all orders were entered and correct. The nursing department should have followed these steps to ensure these orders were placed.	F 690		
F 761 SS=E	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	F 761		2/21/24

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F 761	Continued From page 9 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 and staff interviews, the facility failed to date opened multi-dose vials of insulin medication in 1 of 5 medication administration carts (100 hall), discard loose pills in the medication cart drawer for 2 of 5 medication administration carts (100 hall cart and 200 hall cart), and failed to lock 1 of 5 medication administration cart (200 hall cart). Findings Included: 1.a. On 1/21/24 at 9:10 AM, an observation of the medication administration 200 hall cart with Nurse	F 761	F761-Label/Store Drugs and Biologicals: 1. No resident was harmed by this deficient practice 2. Current med carts have been cleaned and loose pills removed, all multi dose vials have start dates indicated 3. Current licensed nurses will be educated on drug labeling and storage and ensuring carts remain locked when unattended. This education will be completed by 2/9/24 by the staff development coordinator or designee. Licensed nursing staff not receiving education will not be allowed to work until	

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F 761

Continued From page 10

#2 revealed one opened and undated multi-dose vial of Humalog insulin and two opened and undated Novolog Flex Pens (insulin). A review of the manufacturer's literature indicated to discard Humalog multi-dose vial and Novolog Flex Pen 28 days after opening.

On 1/21/24 at 9:20 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift.

1.b.
On 1/21/24 at 9:10 AM, an observation of the medication administration 200 hall cart with Nurse #2 revealed in the second drawer of the medication cart, which contained over the counter medications, there were noted two white loose pills and one yellow round shaped loose pill.

On 1/21/24 at 9:20 AM, during an interview, Nurse #2 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #2 did not clean the cart before her shift.

On 1/23/24 at 11:10 AM, during an interview, the Administrator indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all

F 761

education received.
New licensed nursing staff will receive education within the orientation process by the Staff Development Coordinator.
4. DON or designee will audit carts for 5 x weekly x 4 weeks then 3X weekly for 4 weeks then weekly for 4 weeks to ensure all opened multidose vials have stop dates, there are no loose pills in cart, and carts are locked when not in use.
5. The Director of Nursing will provide the results of the audits for review at Quarterly Quality Assurance Meeting X 1 for further resolution if needed.

6. Date of completion 2/21/2024

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F 761	Continued From page 11	F 761		

the medications in medication administration carts for expiration date and remove expired medications every shift. He expected that no expired items or loose pills be left in the medication carts.

2.
On 1/21/24 at 9:35 AM, an observation of the medication administration 100 hall cart with Nurse #3 revealed in the second drawer of the medication cart, which contained over the counter medications, there were noted four white, two yellow and two purple round shape loose pills. In the third drawer of the medication cart, which contained over the counter medications, there were noted two white oval shaped loose pills.

On 1/21/24 at 10:00 AM, during an interview, Nurse #3 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #3 did not clean the cart before her shift.

On 1/23/24 at 11:10 AM, during an interview, the Administrator expected no loose pills to be left in the medication carts.

3.
On 1/21/24, during the continuous observation on 200 Hall from 9:05 AM to 9:25 AM, the medication administration cart, located in front of the nurses' station, was unlocked, unattended, with push button in the sticking out, unlocked, position. Nurse #2, assigned for the medication administration cart, was observed administered medications at different medication administration cart on the opposite end of 200 hall.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 On 1/21/24 at 9:25 AM, during an interview, Nurse #2 indicated that on 1/21/24, she left the medication administration cart to start the medication administration on another cart. Nurse #2 stated she should not have walked away from the cart without pushing the lock button in the lock position. On 1/21/24 at 10:50 AM, during an interview, the Director of Nursing indicated that the nurses were responsible for keeping the medication cart locked at any time, when they were not at the cart. On 1/22/24 at 1:20 PM, during an interview, the Administrator indicated it was nurses' responsibility to have the medication administration cart locked if the nurse needs to leave the cart.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to provide food in the form prescribed by the physician for 1 of 8 residents observed during lunch (Resident # 95). The findings include: Resident was admitted to the facility on 12/11/23 with diagnoses that included Congestive heart	F 805	F805-Food in Form to Meet Individual Needs: 1. Resident #95 did not receive the prescribed food form as ordered by the physician. 2. Current residents are at risk for this deficient practice. 3. Current resident ordered diets in PCC will be audited and compared to the	2/21/24

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F 805	Continued From page 13 failure, Acute respiratory failure, Diabetes mellitus Type 2 and Dysphagia. Review of the Physician's order dated 12/15/23 revealed the resident was on a Dysphagia pureed texture dirt with nectar thick liquid consistency. Review of the admission Minimum Data Set (MDS) assessment dated 12/18/23 revealed the resident was assessed severely cognitively impaired. The resident needed partial to moderate assistance with eating. Assessment indicated the resident had complaints of difficulty or pain when swallowing and was on mechanically altered diet. The resident was also assessed as having mouth or facial pain, discomfort, or difficulty with chewing. Review of the care plan date 12/22/23 revealed resident was care planned for nutrition - due to risk for weight loss or malnutrition related to cognitive impairment, poor appetite, and history of Cerebrovascular accident (CVA) and requiring dysphagia pureed diet with nectar thick liquids. The goal was to maintain optimal nutrition and hydration status. Intervention included encouraging the resident to eat, recording meal % intake, reviewing dietary preferences with the resident as needed, providing supplements as ordered (med pass), and providing therapeutic diet as ordered. During a lunch meal observation on 1/21/24 at 12:00 PM, Resident was observed eating in his lunch in his room. Review of the resident meal ticket read " Regular Dysphagia Pureed, Nectar thick liquid". Review of the meal tray revealed the resident	F 805	dietary ticket system. This will be completed by the Director of Nursing and Dietary manager by 2/16/2024. 4. Current nursing staff were educated on the importance of following meal tickets and correct food consistency. This education is completed by the Staff Development Coordinator or designee on 1/30/2024. Current dietary staff will be educated by the dietary manager on following tray tickets when plating food. This education will be completed by 2/16/2024. Any nursing or dietary staff who are not educated will not be allowed to work until education is received. New nursing and dietary staff will be educated by the Staff Development Coordinator and Dietary Manager will receive education during the orientation process. 5. The dietary manager or designee will audit, and document findings related to food meeting the individual needs of the residents daily x5 for 4 weeks then 3x weekly x 4 weeks, then weekly x 4 weeks. 6. The Dietary Manager or designee will report Findings to the QAPI committee monthly for review, evaluation, and further recommendations as indicated. 7. Date of completion: 2/21/2024	

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F 805	Continued From page 14	F 805		

received mashed potato, ground meat and green colored food semi liquid consistency in a bowl. Resident had consumed 70% of the ground meat and indicated he liked the meat.

Nurse #1 was immediately called to resident's room. During an observation and interview on 1/21/24 at 12:05 PM, Nurse #1 indicated the resident was on a pureed diet and based on the meat served to the resident it appeared to be ground meat. She further stated that the pureed vegetable in the bowl was not of pureed consistency and very liquid.

The Director of Nursing (DON) was called to the resident room on 1/21/24 at 12:08 PM. The DON observed the tray and indicated the meat looked like ground meat and the pureed vegetable was not of appropriate pureed consistency and was very liquid. DON indicated she would replace the resident meal tray with the correct diet tray. The tray was removed.

During an interview on 1/21/24 at 1:25 PM, the Dietary Manager stated the facility had 5 residents on pureed diet. She indicated all textured diets had to be on the correct consistency. The dietary cook was responsible to ensure the food was of correct texture and the dietary aide at the end of the tray line was responsible to check all trays for accuracy prior to placing the dome on the tray and placing the tray on the cart.

During an interview on 1/21/24 at 1:35 PM, the dietary cook stated he had prepared the pureed food at correct consistency, however when he had placed the food in the steamer to reheat, the consistency had broken down and became

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F 805	Continued From page 15	F 805		

thinner that the pureed consistency. He stated he had added thicker to the food to make the appropriate consistency, however it did not thicken as expected.

During an interview on 1/21/24 at 1: 40 PM, the dietary aide #1 stated she was at the end of the tray line and was checking for tray accuracy. She indicated she had overlooked ground meat on resident's tray.

During an interview on 1/23/24 at 11:00 AM, the rehab director the resident was seen by speech therapist and was on pureed diet with thickened liquids due to dysphagia. The speech therapist was unavailable for the interview.

During an interview with the RD on 1/23/24 at 2:30 PM, he stated the resident was on pureed diet with Nectar thick liquid per speech therapy recommendations. The resident has dysphagia. The RD stated the resident should be provided with appropriate diet texture and consistency due to his swallowing issues.

During an interview on 1/23/24 at 4:30 PM, the DON stated the dietary staff, and the nursing staff were responsible for checking the resident's trays for accuracy before serving the trays to the residents. She further stated the dietary staff should ensure the food was prepared/cooked to correct consistency before it was served on the meal tray for the resident.

During an interview on 1/24/24 at 2:43 PM, Nurse Practitioner (NP) stated the resident has dysphagia and was at risk of aspiration if correct diet texture was not provided. He indicated staff should be monitoring the resident meal tray to

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F 805	Continued From page 16 ensure that the correct consistency was provided. He indicated some steps had to be put in place so that this issue does not repeat. During an interview on 1/24/24 at 2:46 PM, the Administrator stated residents should receive appropriate textures per physician orders and for residents' safety. The kitchen should ensure the diet consistency and textures were correct for all residents.	F 805		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to honor the food preferences for 4 of 10 residents observed during dining (Resident # 249, Resident # 86, Resident # 100, and Resident # 21). Findings included: 1. Resident # 249 was admitted to the facility on 1/17/24 with diagnoses that included diabetes mellitus type2 and peripheral vascular disease. Review of the physician orders dated 1/18/23	F 806	F806-Resident Allergies, Preferences, Substitutes: 1. Resident□s #249, #86, #100, and #21 did not have their food preferences updated to show likes, dislikes, and allergies 2. Current residents are at risk 3. The dietary manager and corporate dietician have updated food preferences for every resident in the facility to ensure residents are receiving items they like, and substitutions are provided for items if not available by 2/16/2024.	2/21/24

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F 806

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revealed the resident was on a heart healthy diabetic diet, regular texture, and thin liquids.

Resident's admission minimum data set (MDS) assessment dated1/24/24 revealed the assessment was in progress.

During a lunch meal observation on 1/21/24 at 12:10 PM, Resident #249 was observed eating her meals in her room. Review of the resident's meal tray revealed whole milk -8 fluid ounces (Fl. oz).

Observation of the resident's meal tray revealed no milk was served on the tray. During an interview with the resident on 1/21/24 at 12:10 PM, she indicated she likes whole milk with meals and has not been receiving it. Resident #249 stated the food preferences were taken at admission and she was informed at admission that she would receive what was on the menu. Resident #249 further stated that she never receives all items on the meal ticket.

Observation of the meal cart on the hallway revealed no milk cartons on or inside the cart. During an interview on 1/21/24 at 12:18 PM, Nurse aide #2 indicated she was unsure why there was no milk on the resident's tray. She indicated the milk was usually served on the resident's meal trays by the kitchen.

During an interview on 1/21/24 at 12:40 PM, the Dietary Manager stated the milk carton were frozen as these were accidentally placed in the freezer. She further stated the milk cartons were sent out on the meal carts and not on the meal tray. She indicated she had personally brought milk for some residents. She was unsure why the

F 806

4. Current Dietary staff have been educated in resident allergies, preferences, and substitutions. Staff have been educated in checking tickets for substitutions to match resident preferences. This education was completed by the Dietary Manager on 2/16/2024.
Current dietary staff will not be allowed to work until their education has been completed.
New Dietary staff will be educated on food allergies, preferences, and substitutes during orientation. This education will be completed by the Dietary Manager.
5. The dietary manager or designee will audit, and document findings related to food allergies, preferences, and substitutes daily x5 for 4 weeks., then 3x weekly x 4 weeks, then weekly x 4 weeks.
6. The Dietary Manager or designee will report Findings to the QAPI committee monthly for review, evaluation, and further recommendations as indicated.
7. Date of completion: 2/21/2024

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resident did not receive whole milk on her tray.

During a breakfast meal observation on 1/22/24 at 9:10 AM, the resident was observed in her room with her meal tray in front of her. Observations of the meal tray revealed the resident received 1% milk carton. Review of the meal ticket indicated whole milk - 8 fl.oz.

During an interview on 1/22/24 at 9:10 AM, the resident indicated she was upset as she was not receiving whole milk. She stated she disliked 1% milk and preferred whole milk as indicated on her meal ticket.

During an interview on 1/22/24 at 9:15 AM, Nurse Aide #1 indicated that all residents received either 1% or 2% milk on their tray instead of whole milk and she was unsure why the kitchen has not sent out the whole milk.

During an interview on 1/23/24 at 2:40 PM, the Dietary Manager stated the facility did not have any whole milk cartons due to some supply issue with the vendor.

During an interview on 1/23/24 at 2:45 PM, the Regional Culinary Director stated there have been some issues related to vendor fulfilling the order for individual whole milk cartons. He further stated it was like a supply chain issue. The regional Culinary Director further stated that if whole milk was unavailable the kitchen should substitute with 2% milk cartons and inform the nursing staff about the substitution so that the residents were made aware of the changes and the reason for the change.

2. Resident # 86 was admitted on 12/14/23 with

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diagnoses that included dysphagia.

Physician orders dated 12/14/23 indicated Resident #86 was on Heart Healthy diet, Dysphagia Pureed texture, Thin Liquids consistency diet.

Review of the admission MDS assessment dated 12/21/23 indicated the resident was severely cognitively impaired and was on a mechanically altered, therapeutic diet.

During a lunch observation on 1/21/24 at 12:11 PM, Resident # 86 was observed eating her meals in her room. Review of the resident meal ticket revealed whole milk - 8 FL oz and Note that read "send ice cream".

Observation of the meal tray revealed the resident did not receive milk or ice cream. When asked if the resident liked milk and ice cream, Resident #86 indicated like both milk and ice cream.

Observation of the meal cart on the hallway revealed no milk cartons on or inside the cart. During an interview on 1/21/24 at 12:18 PM, Nurse aide #2 indicated she was unsure why there was no milk on the resident's tray. She indicated the milk was usually served on the resident's meal trays by the kitchen.

During an interview on 1/21/24 at 1:35 PM, the dietary cook indicated that milk should not be on the lunch and dinner meal ticket. The dietary cook stated the facility's previous dietary manager was trying to remove milk from all lunch and dinner meal ticket. He indicated milk should only be served during breakfast.

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During an interview on 1/21/24 at 1:38 PM, dietary aide #2 stated there was no ice -cream (vanilla, strawberry, chocolate flavor) available and hence were not on the resident's tray.

During an interview on 1/21/24 at 12:40 PM, the Dietary Manager stated the milk carton were frozen as these were accidentally placed in the freezer. She further stated the milk cartons were sent out on the meal carts and not on the meal tray. She indicated she had personally brought milk for some residents. She was unsure why the resident did not receive milk on her tray. The Dietary Manager stated the kitchen had sherbet and pudding available for the resident. She further stated sherbet or pudding could have been substituted for ice cream.

3. Resident # 100 was admitted on 1/16/24 with diagnoses that included protein calories malnutrition, congestive heart failure, and chronic atrial fibrillation.

Physician order dated 1/17/23 revealed the resident was ordered a Heart Healthy diet, Regular texture, Thin Liquids diet.

Resident #100's Admission MDS dated 1/23/24 was in progress.

Review of the social worker note "discharge planning summary" dated 1/23/24 revealed the resident was cognitively intact and could communicate her needs.

During a lunch observation on 1/21/24 at 12:14 PM, Resident #100 was observed eating her meals in her room. Review of the resident meal

F 806 Continued From page 21 F 806

ticket revealed milk 2% - 8 FL oz. Observation of the meal tray revealed the resident did not receive milk.

During an interview on 1/21/24 at 12:14 PM, the resident indicated she likes having milk with her meals and it was constant that milk was missing from her tray. Resident indicated her food preferences were taken at the time of admission.

Observation of the meal cart on the hallway revealed no milk cartons on or inside the cart. During an interview on 1/21/24 at 12:18 PM, Nurse aide #2 indicated she was unsure why there was no milk on the resident's tray. She indicated the kitchen usually placed milk cartons on the resident's meal trays and send the cart to the hallway.

During an interview on 1/21/24 at 1:35 PM, the dietary cook indicated that milk should not be on the lunch and dinner meal ticket. The dietary cook stated the facility's previous dietary manager was trying to remove milk from all lunch and dinner meal ticket. He indicated milk should only be served during breakfast.

During an interview on 1/21/24 at 12:40 PM, the Dietary Manager stated the milk carton were frozen as these were accidentally placed in the freezer. She further stated the milk cartons were sent out on the meal carts and not on the meal tray. She was unsure why the residents on the hallway did not receive milk on their carts.

4. Resident # 21 was admitted on 11/22/23 with diagnoses that included pneumonia, cirrhosis of the liver and diabetes mellitus Type 2.

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Physician order dated 11/22/23 indicated the resident was on a Heart Healthy Diabetic diet, Regular texture, Thin Liquids consistency.

Review of the admission MDS assessment 11/29/23 revealed the resident was assessed as cognitively intact and was independent with eating.

During a lunch observation on 1/21/24 at 12:14 PM, Resident #21 was observed in her room with her lunch tray in front of her. Review of the resident meal ticket revealed whole milk - 8 FL oz and Note: send ice cream. Observation of the meal tray revealed the resident did not receive milk or ice cream.

During an interview on 1/21/24 at 12:14 PM, Resident #21 stated that milk and ice cream were always an issue with her meal tray. She indicated she received them occasionally. Resident #21 further stated she preferred to have an ice cream after her meal.

Observation of the meal cart on the hallway revealed no milk cartons on or inside the cart. During an interview on 1/21/24 at 12:18 PM, Nurse aide #2 indicated she was unsure why there was no milk on the resident's tray. She indicated the kitchen usually placed milk cartons on the resident's meal trays and send the cart to the hallway.

During an interview on 1/21/24 at 1:35 PM, the dietary cook indicated that milk should not be on the lunch and dinner meal ticket. The dietary cook stated the facility's previous dietary manager was trying to remove milk from all lunch and dinner meal ticket. He indicated milk should only be

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F 806	Continued From page 23 served during breakfast. During an interview on 1/21/24 at 1:38 PM, dietary aide #2 stated there was no ice -cream (vanilla, strawberry, chocolate flavor) available and hence were not on the resident's tray. During an interview on 1/21/24 at 12:40 PM, the Dietary Manager stated the milk carton were frozen as these were accidentally placed in the freezer. She further stated the milk cartons were sent out on the meal carts and not on the meal tray. She was unsure why the residents did not receive milk on her tray. The Dietary Manager stated the kitchen had sherbet and pudding available for the resident. She further stated sherbet or pudding could have been substituted for ice cream. During an interview on 1/23/24 at 4:50 PM, the Director of Nursing (DON) stated the kitchen should notify the nursing staff if there were any menu substitutions so that the residents were made aware. The DON further stated resident's food preferences were taken at admission and all resident's food preferences should be honored as long as the food preferences did not conflict with their diet order. The DON indicated it was her expectation that the nurse aides check the meal trays for accuracy when setting up the tray for residents during meals. The nursing staff should notify the kitchen about any tray inaccuracies and resident's food preferences when indicated by the resident. During an interview on 1/24/24 01:52 PM, the Administrator indicated the meal trays should be reviewed by staff for accuracy, diet, and preferences. Residents should be served meals	F 806		

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F 806	Continued From page 24 based on their preferences. Care should be taken to accommodate the likes and dislikes of the residents.	F 806		
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 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 keep food preparation areas, food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the floor and ceiling vents located over the food prep and food service area. This practice had the potential to affect food served to all residents. The findings included:	F 812	F812-Food Procurement, Store/Prepare/Serve-Sanitary: 1. The kitchen vents and equipment were properly cleaned and disinfected on 01/23/2024 2. The dietary manager created a new cleaning schedule for staff to follow each day with assigned cleaning assignments on 01/23/2024. 3. The dietary manager has created and released a cleaning schedule for staff with	2/21/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 25	F 812		

During a kitchen tour on 1/21/24 at 9:14 AM, the following observations were made with the kitchen Cook:

a. The 6- stove burners had heavy grease build-up on the stove burners, walls behind the stove, and front of the stove. There were large amounts of burnt foods, dried, encrusted, liquid and splatters throughout the stove area. The inside and outside of the combination stove and oven doors had grease buildup, dried foods, and liquid spills.

b. The 4-compartment ovens had a heavy grease build-up, dried food, and liquids on the inside and outside. The grease buildup was encrusted on doors/shelves where food was being cooked. There was a dried grease buildup observed on the fronts of the ovens and on the walls on the inner walls of the oven or on the walls behind the oven.

c. The fryer had dried brown/yellow liquid matter encrusted on edges inside and outside. The fryer had heavy grease and food build-up inside and outside, food products behind the fryer.

d. The 3 plate warmers had 2 rows of clean plates stored in the warmer. The inside of warmer had dried liquid spills and food particles inside and dried liquid spills on the outside. The inside also had old food crumbs all around.

e. The 3-compartment insulated plate base warmer had 3 rows of clean bases stored in the warmer. The inside had dried liquid spills and food particles inside and outside. The inside also had old food crumbs all around. The 2 bottom covers warmers had 2 rows of clean bottom

areas of the kitchen they are responsible for cleaning.
Current Dietary staff have received in-service education on the importance of properly cleaning the kitchen area, and ensuring proper sanitation occurs daily. Education was done by Dietary Manager.

Dietary staff will not be allowed to work until education has been received.
New dietary staff will be educated on proper sanitation and cleaning schedule by the Dietary manager during the orientation process.
4. The dietary manager or designee will audit, and document findings related to food procurement and sanitation 5x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4 weeks.
5. The Dietary Manager or designee will report Findings to the QAPI committee monthly for review, evaluation, and further recommendations as indicated.
6. Date of completion: 2/21/2024

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covers stored with a large volume of liquid spills, food particles inside and dried liquids spills on the outside. The inside also had old food crumbs all around.

f. The floor underneath the stove, fryer, steamer, and ovens had large amounts of dried food, grease puddles and trash.

g. The 4 ceiling vents and 2 air conditioning units had large volumes of black dust/debris blowing over food service and prep surfaces.

h. The 3 shelves drying rack had 12 steam table lids, 9 plastic storage containers, 15 silver cooking pans stored on dirty rack, that had a large volume of dried liquids and food crumbs/particles.
i. The walls behind the hand wash sink had a knife storage rack which had food splashed all over the wall and the knife storage rack.

j. There were 2 refrigerators that had left over food and dried liquids on the walls inside and outside.
An interview was conducted on 1/21/24 at 9:35 AM, Cook #1 stated there was no cleaning checklist, available . He further stated he was unaware of when the kitchen equipment was last cleaned.

An observation was conducted on 1/21/24 at 10:04 AM, the Dietary Aide #1(DA) placed 2 rows of clean plates in the plate warmer and 3 rows of clean plate bases into the base warmer. When asked when the last time was the plate and base warmer had been cleaned the response was "I don't know, and I am not sure if there was a cleaning checklist." DA #1 stated there were not

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F 812	Continued From page 27 enough staff to clean and cook and they were doing the best they could to get things done and the meal served. An interview was conducted on 1/22/24 at 10:15 AM, the DA#2 stated all staff try to pitch in a much as possible to clean the kitchen after each shift, if the scheduled staff does not show up, it put them even further behind and some things may get wiped down when it should really be deep cleaned. An interview was conducted on 1/22/24 at 11:30 AM, Cook #2 stated there was a cleaning checklist, but the Dietary Manager (DM) kept that information in the office. She further stated she was unaware of when the kitchen equipment was last cleaned. Follow-up observation was conducted on 1/23/24 at 11:17 AM-12:30 PM, the previous identified kitchen concerns of the kitchen equipment, food prep areas, floors, ceiling vents and air condition remained in the same condition as the initial tour on 1/21/24. An interview was conducted on 1/22/42 at 11:45 AM, the Dietary Manager (DM), and Regional Dietician (RD) stated the kitchen staff were required to wipe down kitchen equipment after each meal and deep cleaned weekly in accordance with the kitchen cleaning checklist. The DM and Regional Dietician further stated they were responsible for ensuring the kitchen staff kept the equipment clean and orderly. The Dietary Manager (DM) and Regional Dietician(RD) acknowledged the identified kitchen equipment, the floors, ceiling fan and air condition units had not been cleaned in several months. The DM stated all cleaning checklists and	F 812		

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F 812	Continued From page 28 responsibilities would be updated and available for all kitchen staff. An interview was conducted on 1/23/24 at 1:34 PM, the Administrator stated the Dietary Manager and Kitchen Supervisor were responsible for ensuring the kitchen was cleaned and maintained. The Administrator stated the expectation would be for the Dietary Manager to ensure all kitchen cleaning protocols were in place and followed in accordance with kitchen sanitation guidelines.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance	F 867		2/21/24

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indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through

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F 867	Continued From page 31 (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification and complaint surveys dated 12/8/22, and 7/30/21 and for the complaint investigation survey dated 11/9/23 to achieve and sustain compliance. These were for recited deficiencies on a recertification and complaint investigation survey on 1/24/24. The deficiencies were in the following areas: label/ store drugs and biologicals, food procurement, store/prepare/serve - sanitary and resident records- identifiable information. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program. The findings included: This tag is cross-referenced to: 1. F761 - Based on observations and staff interviews, the facility failed to date opened multi-dose vials of insulin medication in 1 of 5 medication administration carts (100 hall), discard loose pills in the medication cart drawer for 2 of 5 medication administration carts (100 hall cart and 200 hall cart), and failed to lock 1 of 5 medication	F 867	F867-QAPI/QAA Improvement Activities: 1. QAPI will take place on the last Monday of each month and include all department heads. The Medical Director and Pharmacists will be invited monthly and required for quarterly meetings. F761 Nurses were educated on 1/30/24 on dating opened insulin and locking medication carts when not attended. Unit managers conduct daily rounds on medication carts to ensure loose pills are discarded daily. F812 Dietary Manager created an equipment cleaning schedule for staff with daily cleaning responsibilities. All kitchen equipment thoroughly cleaned on 1/23/24. Dietary Manager conducts daily rounds on kitchen equipment cleanliness. F842 Nurses were educated on 1/30/24 on maintaining complete and accurate medical records. DON or designee monitors documentation daily and concerns are shared in clinical meetings daily with follow up at daily stand-down meetings. 2. Monthly meetings will resume to discuss Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI)	

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Continued From page 32

administration cart (200 hall cart).

During a previous recertification and complaint investigation survey on 12/8/22, the facility failed to: 1) Discard expired medications stored in 3 of 3 medication (med) carts observed (200 Middle Hall Med Cart; 200 High Hall Med Cart; and the 100 High Hall Med Cart); and 2) Store medications in accordance with the manufacturer's storage instructions in 1 of 3 med carts observed (200 High Hall Med Cart).

2. F812 - Based on observations and staff interviews, the facility failed to keep food preparation areas, food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the floor and ceiling vents located over the food prep and food service area. This practice had the potential to affect food served to all residents.

During a previous recertification and complaint investigation survey on 12/8/22, the facility failed to keep food preparation areas, food storage areas and food service equipment clean, free from debris, grease buildup, and/or dried spills during two kitchen observations. The facility failed to clean the ceiling vents and air condition units located over the food prep and food service area. This practice had the potential to affect food served to all residents.

During a previous recertification and complaint investigation survey on 7/30/23, the facility failed to label and date stored food items in the walk-in freezer, discard foods with expired use by date in the walk-in refrigerator, ensure bread products were labeled so staff knew how long the bread

F 867

programs. Meetings will focus on quality deficiencies and performance improvement projects, which will be documented in the QAPI/QAA meetings.

3. The Administrator or designee will document the indicators being monitored, current Performance Improvement Plans, current audits, and new plans of action to correct identified quality deficiencies. The progress of Performance Improvement Plans and audits will be monitored by the Administrator or designee weekly and discussed at the next QAPI meeting to be adjusted or continued if needed.
The administrator provided in-service education to all department heads as to the new process on 2/14/2024.

4. The administrator or designee will audit, and document findings related to Quality Assurance and Performance Improvement (QAPI) and Quality Assessment and Assurance (QAA) monthly x3, then quarterly x2. This will be reported to the QAPI committee monthly for review, evaluation, and further recommendations as indicated.

5. The Administrator will provide the results of the audit will be reviewed at monthly Quality Assurance meeting x1 for further resolution if needed

6. Date of Completion 02/21/2024

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F 867	Continued From page 33 could be utilized and discard food in 1 of 2 nourishment refrigerators reviewed for food storage (100 - hallway). 3. F842 - Based on record reviews, staff interviews, and interview with the Nurse Practitioner, the facility failed to maintain complete and accurate medical record for an admission assessment 1 of 2 residents (Resident #201) reviewed for respiratory care. During a complaint investigation on 11/9/23, the facility failed to maintain complete and accurate medical records when Nurse #1 failed to document a change in a resident's status for 1 of 1 resident reviewed for respiratory care. During an interview on 1/24/24 at 3:23 PM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated deficiencies the Administrator stated the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze the cause of repeat deficiency. The Administrator indicated once the plan was put in place, audits and the monitoring phase would be completed. He further indicated that sporadically monitoring and auditing throughout the year should be continued to ensure the repeated deficiencies do not recur. The repeated concerns were also discussed in QA meeting and the QA committee would see how the approach can be changed if needed. This could be education and training of staff or revision of the approach or new	F 867		

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information

CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Continued From Page 1

by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record reviews, staff interviews, and interview with the Nurse Practitioner, the facility failed to maintain complete and accurate medical record for an admission assessment 1 of 2 residents (Resident #201) reviewed for respiratory care.

Findings Included:

Resident #201 was admitted to the facility on 2/18/23 at 12:30 AM. According to the census list the resident was discharged from the facility on 2/18/23 at 2:00 AM, which was in one and a half hours on the same day.

Record review of the nurses' notes from 7 PM on 2/17/23 to 7 AM on 2/18/23 revealed no entries regarding the resident's condition.

On 1/23/24 at 1:20 PM, during the phone interview, Nurse #4, who was assigned to Resident #201 during the 7 PM-7 AM shift on 2/18/2023, indicated that alert and oriented Resident #201 was admitted via Emergency Medical Service (EMS) at 12:30 AM on 2/18/23. Resident #201 left the facility to the Emergency Room (ER) at 2:00 AM. Nurse #4 confirmed that she documented in computer medical records the resident's assessment and vital signs, including oxygen saturation.

On 1/24/24 at 1:50 PM, during an interview, DON expected nurses to document a resident's condition in the medical records. The DON continued that Nurse #4 should have documented the resident's admission assessment, including the vital signs, condition, her phone call to DON, and the discharge to ER via EMS in the medical records.

On 1/24/24 at 2:15 PM, during an interview, the Administrator indicated that the staff was responsible for documenting the resident's condition in medical records.