STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 08/01/2024

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CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/29/24 through 08/01/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IJEI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/29/24 through 08/01/24. Event ID# IJEI11. The following intakes were investigated NC00217923 and NC00219990. One (1) of the 4 complaint allegations resulted in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		8/26/24

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

Electronically Signed | 08/22/2024

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews, the facility failed to immediately notify a resident's Responsible Party of a medication change for 1 of 1 sampled resident (Resident #23). Findings included: Resident #23 was admitted to the facility on 06/03/24 with diagnoses that included dementia.	F 580	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. Plan of Correction-F580	

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F 580	Continued From page 2 The admission Minimum Data Set (MDS) dated 06/08/24 assessed Resident #23 with severe impairment in cognition. Review of Resident #23's profile revealed his family member was listed as his Responsible Party (RP). A Physician Assistant (PA) progress note dated 07/24/24 revealed in part, staff administered Resident #23's as needed (PRN) Lorazepam at times which was reported to be generally effective. The plan was to change Resident #23's current order for PRN Lorazepam from every 8 hours to every 12 hours and start scheduled Lorazepam (medication used to treat anxiety) 0.25 milligrams (mg) once daily at 4:00 PM. The PA noted the medication change was discussed at length with Resident #23's private sitter. A physician order entered by the PA with a start date of 07/24/24 read, Lorazepam 0.5 milligram (mg) - give 0.5 (1/2) tablet by mouth one time a day for anxiety, note dose. A physician order entered by the PA with a start date of 07/24/24 read, Lorazepam 0.5 mg every 12 hours PRN anxiety for 14 days. During a telephone interview on 07/30/24 at 9:57 AM, Resident #23's RP revealed the private sitter was just a companion and not able to make decisions regarding Resident #23's care. The RP stated she had met with Unit Manager #1 and the Administrator on previous occasions and requested they send her weekly emails to provide updates on Resident #23's condition to include any medication changes. The RP stated she was not notified his Lorazepam medication had	F 580	This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to notify resident #23□s responsible party of a medication change. A review of all medication changes in the last 7 days for resident #23 was completed on 8-2-24 by the DON to ensure all other medication changes had been properly communicated to the responsible party. DON/designee will update patient□s responsible parties of changes to medication regimen as they occur. DON/designee will audit last 7days of new medication orders to ensure responsible party notification. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents are at risk. DON/designee completed an audit on 8-22-24 of the last 7days of new medication orders to ensure responsible party notifications were completed by the compliance date indicated. DON/designee will ensure all patient□s responsible party	

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F 580	Continued From page 3 changed until she was contacted on Sunday morning (07/28/24) by facility staff to let her know that he had fallen. During an interview on 08/01/24 at 1:54 PM, the PA revealed she did not speak with Resident #23's RP on 07/24/24 when a scheduled dose of Lorazepam was added for Resident #23 but she had discussed the medication change with Resident #23's private sitter who was in agreement with the plan and had appeared to have been texting Resident #23's RP. During an interview on 08/01/24 at 4:53 PM, the Director of Nursing (DON) revealed they met with Resident #23's RP and agreed on weekly emails to communicate any updates. The DON stated she knew that Unit Manager #1 had communicated with Resident #23's RP via email but she was uncertain if or when Unit Manager #1 had informed the RP of the medication change and she would have to touch base with her (Unit Manager #1) when she returned from vacation. During an interview on 08/01/24 at 5:58 PM, the Administrator revealed Resident #23 had a private sitter that was very involved in his care and when staff discussed anything with the private sitter, she sent text messages to Resident #23's RP and they had assumed the private sitter was informing the RP. The Administrator stated she would expect for staff to have called Resident #23's RP to inform them of the medication change and not rely on the private sitter to inform them.	F 580	has been notified of any changes made to the patient□s medication regimen. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed floor nurses employed at Carolina Rehab Center of Burke will be educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on notification of responsible party on medication changes and document. This education will be completed by 8/26/24. Licensed floor nursing staff not receiving education will not be allowed to work until education is received. New licensed floor nursing staff will receive education within the orientation process by the staff development coordinator or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, managers, or designee will audit order listing in morning clinical meeting to ensure notification has been made and documented in progress notes 5 x weekly x 4 weeks, 3 x weekly x 4weeks, monthly x 1. The findings will be reviewed at the quarterly QAPI meetings to review progress. Date of compliance is 8/26/24. The Administrator is responsible for implementing the acceptable plan of correction.	
F 641 SS=E	Accuracy of Assessments	F 641		8/26/24

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F 641	Continued From page 4 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of oxygen therapy, functional limitation in range of motion, dialysis, hospice and prognosis, hypoglycemic medication (used to help reduce the amount of sugar in the blood), and Preadmission Screening and Resident Review (PASRR) for 6 of 20 sampled residents (Residents #23, #71, #130, #74, #38, and #6). Findings included: 1. Resident #23 was admitted to the facility on 06/03/24 with diagnoses that included pneumonia. A physician's order dated 06/04/24 for Resident #23 read, oxygen at 1-2 liters per minute (LPM) via nasal cannula. Review of the June 2024 Treatment Administration Record (TAR) for Resident #23 revealed oxygen at 1-2 LPM was initialed as administered twice daily per physician order. The admission Minimum Data Set (MDS) dated 06/08/24 for Resident #23 did not reflect he received oxygen therapy during the MDS assessment period. During an interview on 08/01/24 at 9:49 AM, the	F 641	F641 MDS Accuracy "F641 This REQUIREMENT is not met as evidenced by the following: The facility failed to accurately code Minimum Data Set (MDS) assessments for 6 out of 20 residents reviewed in the areas of oxygen therapy, functional limitation in range of motion, hypoglycemic medication and Preadmission Screening and Resident Review (PASRR) How corrective action will be accomplished for each resident found to have been affected by the deficient practice: All identified Residents that had inaccuracies identified were corrected by the MDS coordinator when they were made aware of the correction needed. "How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice All current residents can be affected by the alleged deficient practice. All current residents' MDS will be audited by 8-26-24 to ensure that oxygen therapy, functional limitations in range of motion, dialysis, hospice and prognosis, hypoglycemic medication, and PASSR information is accurate. If any errors are noted,	

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F 641	Continued From page 5 MDS Coordinator reviewed the June 2024 TAR for Resident #23 and confirmed the admission MDS assessment dated 06/08/24 did not accurately reflect that he received oxygen therapy during the MDS assessment period. She stated it was an oversight. During an interview on 08/01/24 at 5:58 PM, the Administrator stated she expected MDS assessments to be completed as accurately as possible to reflect an accurate picture of the resident. 2. Resident #71 was admitted to the facility on 06/27/24 with diagnoses that included displaced fracture of surgical neck of right humerus (upper arm bone). A physician order dated 06/27/24 for Resident #71 read, non-weight bearing to right upper extremity. A physician order dated 06/27/24 for Resident #71 read, ensure sling to right arm is in place every shift. Review of the July 2024 Treatment Administration Record (TAR) for Resident #71 revealed the right arm sling was initialed as in place per physician order. The admission Minimum Data Set (MDS) assessment dated 07/03/24 revealed Resident #71 had no impairment of her upper extremities. During an interview on 07/31/24 at 9:20 AM, the MDS Assistant revealed Resident #71 had impairment on the upper extremity due to a right arm fracture. The MDS Assistant stated it was an	F 641	corrections will be made upon discovery. "Measures to be put in place or systemic changes made to ensure practice will not re-occur: MDS Coordinator and MDS RN will be educated by Regional of Director of Clinical Services or designee regarding the need for accuracy when coding information for O2 therapy, functional limitations in range of motion, dialysis, hospice and prognosis, hypoglycemic medication, and PASSR status for the comprehensive care plans to reflect the resident□s status. "How facility will monitor its performance to make sure that solutions are sustained: Regional Director of Clinical Reimbursement or Designee will audit 5 MDS weekly for 4 weeks, 5 MDS biweekly for 2 weeks, and then monthly for one month. Findings from these audits will be reviewed at the monthly Quality Assurance meeting for 3 months minimum. Date of Compliance is 8-26-24. The administrator is responsible for implementing the acceptable Plan of Correction.	

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F 641	Continued From page 6	F 641		

oversight that the admission MDS assessment dated 07/03/24 did not reflect Resident #71 had impairment on one side of the upper extremities.

During an interview on 07/31/24 at 9:25 AM, the MDS Coordinator stated Resident #71's admission MDS assessment dated 07/03/24 should have reflected she had impairment on one side of the upper extremity and it was an oversight.
During an interview on 08/01/24 at 5:58 PM, the Administrator stated she expected MDS assessments to be completed as accurately as possible to reflect an accurate picture of the resident.

3. Resident #130 was admitted to the facility on 07/20/24 with diagnoses that included end-stage renal disease and dependence on renal dialysis.

A physician order dated 07/22/24 for Resident #130 read in part, dialysis three times a week on Tuesday, Thursday and Saturday.

The admission Minimum Data Set (MDS) dated 07/25/24 revealed that Resident #130 received dialysis and hemodialysis upon admission but did not receive either while a resident.

During an interview on 07/31/24 at 9:20 AM, the MDS Assistant stated it was an oversight that Resident #130's admission MDS assessment dated 07/25/24 did not accurately reflect she received dialysis while a resident.

During an interview on 07/31/24 at 9:25 AM, the MDS Coordinator stated it was an oversight that Resident #130's admission MDS assessment dated 07/25/24 did not accurately reflect she

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F 641	Continued From page 7	F 641		

received dialysis while a resident.

During an interview on 08/01/24 at 5:58 PM, the Administrator stated she expected MDS assessments to be completed as accurately as possible to reflect an accurate picture of the resident.

4. Resident #74 was admitted to the facility 07/13/24 with a diagnosis including diabetes.

Review of Resident #74's physician orders revealed an order dated 07/13/24 for insulin degludec 200 units per milliliter (ml) inject 30 units subcutaneously (under the skin) one time a day for diabetes. Resident #74 had a physician order dated 07/17/24 to discontinue insulin degludec 30 units once a day and begin insulin degludec 34 units subcutaneously at bedtime. Resident #74 had a physician order dated 07/18/24 to discontinue insulin degludec 34 units at bedtime and begin insulin degludec 40 units subcutaneously at bedtime. Resident #74 had an order dated 07/16/24 for insulin lispro 100 units per ml inject 4 units subcutaneously one time only for diabetes.

Review of Resident #74's July 2024 Medication Administration Record (MAR) revealed he received insulin as ordered.

Resident #74's admission Minimum Data Set (MDS) assessment dated 07/19/24 did not reflect he received hypoglycemic (medication to lower blood sugar) medication during the look-back period.

An interview with the MDS Coordinator on 08/01/24 at 4:44 PM revealed Resident #74's admission MDS dated 07/19/24 should have

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F 641	Continued From page 8	F 641		

been coded to indicate he received hypoglycemic medication during the past 7 days, and it was an oversight.

An interview with the Administrator on 08/01/24 at 6:04 PM revealed she expected the MDS assessment to be coded to reflect an accurate picture of the resident.

5. Resident #38 was admitted to the facility 08/24/22 with diagnoses including malnutrition and adult failure to thrive (a syndrome of physical and cognitive decline in older adults).

Review of Resident #38's medical record revealed he began receiving hospice services on 06/11/24.

Review of a significant change in status Minimum Data Set (MDS) dated 06/11/24 revealed he was not coded as having a condition or chronic disease that may result in a life expectancy of less than 6 months or that he was receiving hospice services.

An interview with the MDS Coordinator on 08/01/24 at 4:34 PM revealed Resident #38's significant change in status MDS dated 06/11/24 should have reflected he had a life expectancy of less than 6 months and was receiving hospice services, and it was probably an oversight.

An interview with the Administrator on 08/01/24 at 6:04 PM revealed she expected the MDS assessment to be coded to reflect an accurate picture of the resident.

6. Resident #6 was admitted to the facility on 05/06/19 with diagnoses that included schizophrenia.

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F 641	Continued From page 9 Record review revealed a PASRR Level II determination notification letter dated 09/16/19 with no expiration date for Resident #6. The significant change in status Minimum Data Set (MDS) assessment dated 04/06/24 revealed Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 08/01/24 at 9:26 AM the Regional Social Worker confirmed Resident #6 had a Level II PASRR determination for the diagnosis of schizophrenia. During an interview on 08/01/24 at 5:58 PM the Administrator revealed she expected the MDS to be as accurate as possible to reflect an accurate picture of the resident.	F 641		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to request a Preadmission Screening and Resident Review (PASRR) re-evaluation after a significant change in the physical or mental status for a resident with a serious mental health diagnosis for 1 of 1	F 646	F646-MD/ID significant change notification 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice: The facility failed to request a	8/26/24

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F 646	Continued From page 10 resident reviewed for PASRR (Resident #6). Findings included: Resident #6 was admitted to the facility on 05/06/19 with diagnoses that included schizophrenia. A PASRR Level II determination notification letter dated 09/16/19 revealed Resident #6 had a Level II PASRR with no end date and no limitation unless there was a change in condition. The significant change Minimum Data Set (MDS) assessment dated 04/06/24 revealed Resident #6 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 08/01/24 at 9:26 AM the Regional Social Worker confirmed there was no request made for a PASRR reevaluation when Resident #6 had a significant change of condition in April 2024. She revealed a request for PASRR should have been done by the previous Social Worker but at that time a change was made in her employment status. The Regional Social Worker confirmed there was no oversight in place to ensure a PASRR request was completed for Resident #6, and stated the new Social Worker was still in training and had just started her position. An interview was conducted on 08/01/24 at 5:10 PM with the Director of Nursing (DON). The DON stated PASRR was the responsibility of the Social Worker, and she was not knowledgeable in the process for requesting PASRR for residents.	F 646	Preadmission Screening and Resident Review (PASSR) re-evaluation after a significant change in the physical or mental status for a resident with a serious mental health diagnosis (resident #6). Regional Discharge planning consultant completed a new PASSR request for resident number #6 on 08-23-24. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice: Regional Discharge Planning consultant will complete an audit of all current residents with a significant change in the last 30 days by 8-26-24 and assess if a new PASSR re-evaluation was needed. Any residents identified will have a new PASSR screening submitted to the North Carolina Department of Health and Human Services (NCDHHS) by 8-26-24. 3.What measures will be put in place or systematic changes made to ensure the deficient practice will not recur: Director of Discharge Planning will be educated by the Regional Discharge Planning Consultant regarding the need to complete a new PASSR screening any time a patient with a mental illness or intellectual disability has a significant change occur to their physical or mental health. Education to be completed by 8-26-24. 4. How will the facility monitor its performance to make sure that solutions are sustained: Regional Discharge Planning Consultant or designee will audit all significant changes weekly for 4 weeks, then all significant changes biweekly for 4 weeks, and then monthly	

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F 646	Continued From page 11 During an interview on 08/01/24 at 6:39 PM the Administrator revealed she expected PASRR requests for reevaluation to be completed and it was the responsibility of the Social Worker to complete.	F 646	for one month to ensure anyone with a mental illness or intellectual disability has had a new PASSR evaluation submitted to NCDHHS. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. Date of completion: 8-26-24. The Administrator is responsible for the implementation of this Plan of Correction.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		8/26/24

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F 656	Continued From page 12 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to develop an individualized, person-centered Activities of Daily Living (ADL) care plan that included how much staff assistance was needed to care for a resident who required assistance with ADL for 1 of 2 sampled residents reviewed for ADL (Resident #71). Findings included: Resident #71 was admitted to the facility on 06/27/24 with diagnoses that included displaced fracture of surgical neck of right humerus (upper arm bone) and displaced fracture of base of neck of right femur (upper bone of the leg). The admission Minimum Data Set (MDS) dated	F 656	F 656 Development and implementation of Comprehensive CP " F656: This REQUIREMENT is not met as evidenced by the following: The facility failed to develop an individualized, person-centered Activities of Daily Living (ADL) care plan that included how much staff assistance was needed to care for a resident who required assistance with ADL care. " How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Upon identification of this alleged deficient practice, the care plan was updated to accurately reflect the assistance needed	

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F 656	Continued From page 13 07/03/24 revealed Resident #71 had intact cognition and required substantial to maximum assistance with toileting hygiene, personal hygiene, shower/bathing, upper/lower body dressing, putting on/taking off footwear, bed mobility, and transfers. Resident #71's comprehensive care plans, last revised on 07/16/24, included a plan that addressed her need for assistance with ADL. The only intervention listed was for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) to evaluate and treat as needed. During an observation and interview on 07/29/24 at 11:16 AM, Resident #71 was lying in bed with bilateral bed rails in the upright position and a sling on her right arm. Resident #71 stated she had broken her arm and hip when she fell at home and was admitted to the facility to receive therapy before returning back home. Resident #71 stated she needed staff assistance with most ADL tasks but was able to hold onto the bed rails with her left hand to help as much as she could when staff were providing her care. During an interview on 07/31/24 at 9:20 AM, the MDS Assistant reviewed Resident #71's ADL care plan and confirmed the only intervention listed was for PT, OT, ST to evaluate and treat as needed. The MDS Assistant explained the care plan should include interventions relating to care needs, such as transfer status and use of bed rails, so that staff would know what level of care to provide. The MDS Assistant stated it was an oversight and Resident #71's ADL care plan should have reflected her care needs.	F 656	to provide appropriate care to resident #71in relation to their ADL needs. " How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice " All current residents have the potential to be affected by the alleged deficient practice. All current residents□ care plans will be audited for accuracy in relation to their ADL care needs by 8-26-24. Any inaccuracies will be corrected upon discovery during the audit process. " Measures to be put in place or systemic changes made to ensure practice will not re-occur: MDS RN and MDS Coordinator will be educated by the Regional Director of Clinical Services by 8-26-24 regarding the need to accurately reflect the ADL needs of each resident to ensure proper assistance during care. " Measures to be put in place or systemic changes made to ensure practice will not re-occur: Regional Director of Clinical Reimbursement or Designee will audit 5 MDS weekly for 4 weeks, 5 MDS biweekly for 2 weeks, and then monthly for one month. Findings from these audits will be reviewed at the monthly Quality Assurance meeting for a minimum of three months or until the IDT team determines compliance. Date of Compliance is 8-26-24. The administrator is responsible for implementing the acceptable Plan of Correction.	

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F 656	Continued From page 14 During an interview on 07/31/24 at 9:25 AM, the MDS Coordinator verified Resident #71's ADL care plan did not include specific interventions that addressed her care needs and it was an oversight. During an interview on 08/01/24 at 5:58 PM, the Administrator stated she would expect for care plans to be developed to accurately reflect the resident's needs.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		8/26/24

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F 657	Continued From page 15 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to revise an advance directive care plan for 1 of 20 residents whose care plans were reviewed for accuracy (Resident #38). Findings included: Resident #38 was admitted to the facility 08/24/22. The significant change in status Minimum Data Set (MDS) assessment dated 06/11/24 revealed Resident #38 was severely cognitively impaired. Review of the form "Medical Orders for Scope of Treatment" (MOST) dated 06/18/24 revealed Resident #38 had Do Not Resuscitate (DNR) Physician orders. Resident #38's electronic medical record revealed a Physician order dated 06/19/24 for Do Not Resuscitate/Do Not Intubate (place a breathing tube). Review of Resident #38's advance directive care plan last revised 07/16/24 revealed he had an advance directive of full code (providing life-saving measures). Interventions included honoring Resident #38's advance directive choices, referring him to the Physician as needed for advance directive changes, and reviewing advance directives with the resident as needed. An interview with the MDS Coordinator on 08/01/24 at 4:34 PM revealed Resident #38's	F 657	F657 Care Plan timing and Revision 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to revise a care plan for an advance directive care plan for 1 of 20 residents whose care plans were reviewed during survey. Upon identification, Resident #38□s care plan was revised to show the correct advance directive. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current resident□s care plans will be audited for accuracy in relation to their advance directives by the Director of Nursing or designee. Audit will be completed and any revisions in place by 8 -26-24. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not recur: MDS Coordinator, MDS RN, and Director of Social work were educated by Region of Director of Clinical Reimbursement or designee regarding the need for updating and completion of the comprehensive care plan to reflect the residents current advanced directives. Education completed by 8-26-24.	

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F 657	Continued From page 16 advance directive care plan should have been updated on 06/18/24 to reflect he was a DNR, and she was not sure why his care plan had not been revised. An interview with the Administrator on 08/01/24 at 6:04 PM revealed she expected care plans to be revised to reflect an accurate picture of the resident.	F 657	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Regional Director of Clinical Reimbursement or Designee will audit 5 MDS weekly for 4 weeks, 5 MDS biweekly for 4 weeks, and then monthly for one month. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. Date of completion: 8-26-24	
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to keep emergency tracheostomy (surgically created airway in the front of the neck) supplies needed for an unplanned extubation (removal of airway tube) or emergency supplies for mechanical ventilation (ambu bag) at bedside and easily accessible for immediate use in an emergency (Resident #56). The facility also failed to post cautionary and safety signs that indicated the use of oxygen (Resident #39, Resident #71, and Resident #23). This affected 4 of 4 residents reviewed for respiratory services.	F 695	Plan of Correction-F695 This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. Address how corrective action will be	8/26/24

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F 695	Continued From page 17 Findings included: 1. Resident #56 was admitted to the facility 07/12/24 with diagnoses including respiratory failure with hypoxia (lack of oxygen), tracheostomy status, and pneumonia. The admission Minimum Data Set (MDS) assessment dated 07/18/24 revealed Resident #56 was cognitively intact and received tracheostomy care. An observation of Resident #56 on 07/30/24 at 2:15 PM revealed she was sitting in her wheelchair in her room. She was observed to have a tracheostomy in place with oxygen at six liters being delivered via a tracheostomy collar. No ambu bag or obturator (a curved tube which helps keep the tracheostomy open in the event of extubation) were observed in Resident #56's room. An observation of Resident #56 on 07/31/24 at 10:35 AM revealed she was resting quietly in bed with her tracheostomy in place and she was receiving six liters of oxygen through her tracheostomy collar. No ambu bag or obturator were observed in Resident #56's room. An observation of the Infection Prevention (IP) Nurse on 07/31/24 at 10:54 AM revealed she placed an ambu bag in Resident #56's room. An observation of Resident #56 on 07/31/24 at 11:14 AM revealed the area around her tracheostomy tube was cleaned and fresh gauze was applied by the Staff Development Coordinator (SDC) Nurse and IP Nurse. No	F 695	accomplished for those residents found to have been affected by the deficient practice: The facility failed to keep emergency tracheostomy supplies needed for an unplanned extubation at bedside for resident # 56. DON/designee immediately placed emergency supplies by resident #56 bedside to include tracheostomy kit/obturator and ambu bag. The facility also failed to post cautionary and safety signs that indicated the use of oxygen on door/door frame for resident #56, #39, #71, and #23. Cautionary signs were ordered on 8-20-24 and will be placed on those patients identified here. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents with tracheostomy and oxygen are at risk. DON/designee completed 100% audit of residents with tracheostomy and oxygen to ensure emergency supplies by bedside and cautionary and safety signs that indicate use of oxygen on resident door/door frame. Audit completed 8-22-24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed floor nurses employed at Carolina Rehab Center of Burke will be educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on emergency supplies needed at bedside for tracheostomy residents. All licensed floor nursing staff employed by Carolina Rehab	

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F 695	Continued From page 18 obturator was observed in Resident #56's room. An interview with the IP Nurse on 07/31/24 at 11:33 AM revealed 2 spare inner cannulas were kept at Resident #56's bedside and she wasn't sure if an obturator was available in the facility. In a follow-up interview with the IP Nurse on 07/31/24 at 3:15 PM she stated she was able to locate an obturator in a tracheostomy kit and she placed the tracheostomy kit in the dresser beside Resident #56's bed. She stated she placed an ambu bag In Resident #56's room earlier on 07/31/24. The IP Nurse stated she was not sure how long an ambu bag and obturator had not been present in Resident #56's room. An interview with the SDC Nurse on 08/01/24 at 9:58 AM revealed she had been employed in the SDC role for approximately a year. She stated she provided education to nursing staff regarding how to clean tracheostomies, but she did not provide education regarding what to do in the event of an accidental extubation. The SDC Nurse stated she was unsure if an ambu bag or obturator needed to be present in a resident's room if they had a tracheostomy. An interview with the Director of Nursing (DON) on 08/01/24 at 5:24 PM revealed every resident with a tracheostomy should have an obturator and ambu bag readily accessible to them in the event of an emergency. She stated she considered storing an ambu bag on the crash cart as being readily accessible and obturators were available in tracheostomy kits that were kept in the supply room. The DON stated if a resident with a tracheostomy did not have a tracheostomy kit in their room, nursing staff had access to the	F 695	Center of Burke will also be educated on cautionary and safety signs that indicate oxygen to be placed on resident's door/door frame. This education will be completed by 8/26/24. Licensed floor nursing staff not receiving education regarding tracheostomy care/emergency supplies at bedside and the use of cautionary and safety signs that indicate oxygen use on resident door/door frame will not be allowed to work until education is received. New licensed floor nursing staff will receive tracheostomy care/emergency supplies by bedside education and the use of cautionary and safety signs that indicate oxygen use on resident door/doorframe within the orientation process by the staff development coordinator or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, managers, or designee will audit residents with tracheostomy and oxygen to ensure tracheostomy emergency supplies are by bedside and cautionary/safety signs that indicate oxygen use is on door/door frame. 5 x weekly x 4 weeks, 3 x weekly x 4weeks, monthly x 1. The findings will be reviewed at the quarterly QAPI meetings to review progress. Date of compliance is 8/26/24. The Administrator is responsible for implementing the acceptable plan of correction.	

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supply room.
2. a. Resident #23 was admitted to the facility on 06/03/24.

A physician's order for Resident #23 dated 06/04/24 read, oxygen at 1-2 liters per minute (LPM) every shift.

The admission Minimum Data Set (MDS) assessment dated 06/08/24 revealed Resident #23 had severe cognitive impairment and did not receive oxygen therapy during the MDS assessment period.

Review of Resident #23's Treatment Administration Record (TAR) for June 2024 and July 2024 revealed he had received continuous oxygen at 1-2 LPM via nasal cannula each shift since 06/04/24.

An observation conducted on 07/29/24 at 10:44 AM revealed Resident #23 lying in bed, sleeping soundly and receiving supplemental oxygen via nasal cannula at 1.5 LPM. There was no sign posted on the door or doorframe of Resident #23's room to indicate oxygen was in use.

Subsequent observations conducted on 07/30/24 at 9:35 AM, 07/31/24 at 9:18 AM and 08/01/24 at 12:50 PM revealed Resident #23 sitting in his wheelchair in the room receiving supplemental oxygen via nasal cannula. There was no sign posted on the door or doorframe of Resident #23's room to indicate oxygen was in use.

b. Resident #39 was admitted to the facility on 07/17/24.

A physician's order for Resident #39 dated

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07/17/24 read, oxygen at 2 liters per minute (LPM) via nasal cannula every shift.

The admission Minimum Data Set (MDS) assessment dated 07/22/24 revealed Resident #39 had intact cognition and received oxygen therapy during the MDS assessment period.

Review of Resident #39's Treatment Administration Record (TAR) for July 2024 revealed she had received continuous oxygen at 2 LPM via nasal cannula each shift.

An observation conducted on 07/29/24 at 10:50 AM revealed Resident #39 sitting in her wheelchair in the room receiving supplemental oxygen via nasal cannula at 2 LPM. There was no sign posted on the door or doorframe of Resident #39's room to indicate oxygen was in use.

Subsequent observations conducted on 07/30/24 at 9:36 AM and 07/31/24 at 9:20 AM revealed Resident #39 in her room receiving supplemental oxygen at 2 LPM. There was no sign posted on the door or doorframe of Resident #39's room to indicate oxygen was in use.

c. Resident #71 was admitted to the facility on 06/27/24.

A physician's order for Resident #71 dated 06/27/24 read, oxygen at 2 liters per minute (LPM) via nasal cannula every shift.

The admission Minimum Data Set (MDS) assessment dated 07/03/24 revealed Resident #71 had intact cognition and received oxygen therapy during the MDS assessment period.

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Review of Resident #71's Treatment Administration Record (TAR) for July 2024 revealed she received continuous oxygen at 2 LPM via nasal cannula each shift.

An observation conducted on 07/29/24 at 10:50 AM revealed Resident #71 lying in bed receiving supplemental oxygen via nasal cannula at 2 LPM. There was no sign posted on the door or doorframe of Resident #71's room to indicate oxygen was in use.

Subsequent observations conducted on 07/30/24 at 9:36 AM and 07/31/24 at 9:20 AM revealed Resident #71 in her room receiving supplemental oxygen at 2 LPM. There was no sign posted on the door or doorframe of Resident #71's room to indicate oxygen was in use.

During an interview on 08/01/24 at 9:59 AM, the Staff Development Coordinator stated for dignity reasons, they did not post oxygen cautionary signage on the doors of residents' rooms.

During an interview on 08/01/24 at 2:37 PM, Nurse #2 revealed she had questioned using oxygen cautionary signage and was told that since it was a non-smoking facility, they did not have to post oxygen cautionary signage on the room doors or doorframes of residents receiving supplemental oxygen as long as the signage was posted on the door of the main entrance to the facility.

During an interview on 08/01/24 at 4:53 PM, the Director of Nursing revealed the facility used to post oxygen cautionary signage on the doors of residents' rooms receiving supplemental oxygen

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F 695	Continued From page 22 but was told that since they were a non-smoking facility, oxygen cautionary signage only had to be posted on the facility's entrance and exit doors.	F 695		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726		8/26/24

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	345526	A. BUILDING _____ B. WING _____	C 08/01/2024

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F 726	Continued From page 23 Based on observations, record review, and interviews the facility failed to educate nursing staff to ensure emergency tracheostomy supplies were immediately available to provide respiratory care needs for 1 of 1 resident reviewed for tracheostomy (surgically created airway in the front of the neck) care. This was for 5 of 5 nurses (Staff Development Coordinator Nurse, Infection Preventionist Nurse, Nurse #1, Nurse #2, and Nurse #3) reviewed for competency. Findings included: Resident #56 was admitted to the facility 07/12/24 with diagnoses including respiratory failure with hypoxia (lack of oxygen), tracheostomy status, and pneumonia. Observations of Resident #56's room on 07/30/24 at 2:15 PM and 07/31/24 at 10:35 AM revealed no ambu bag (a device for mechanical ventilation) or obturator (a curved tube which helps keep the tracheostomy open in the event of dislodgement) were observed in her room. An interview with the Staff Development Coordinator (SDC) Nurse on 08/01/24 at 9:58 AM revealed she had been employed in her current role around a year and she was responsible for orienting and educating all new nursing staff and providing ongoing education to existing nursing staff. She explained new nursing staff received education regarding performing tracheostomy care and suctioning during orientation and she also provided education to existing nursing staff when a new resident with a tracheostomy was admitted to the facility. The SDC Nurse stated she usually contacted respiratory therapy personnel to provide additional education on	F 726	Plan of Correction-F726 This Plan of Correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following Plan of Correction constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to provide education to nursing staff to ensure emergency tracheostomy supplies were immediately available to provide respiratory care needs for resident #56. Director of Nursing (DON)/designee immediately placed emergency supplies by resident #56 bedside and 100% education started to all Licensed floor nursing staff on emergency supplies to be placed by bedside for residents with tracheostomy the same day discovered. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents with tracheostomy are at risk. DON/designee completed 100% audit of residents with tracheostomy to ensure emergency supplies by bedside on 8-16-24. 100% education will be provided to all licensed floor nursing staff on emergency supplies to be placed by bedside for residents with	

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F 726	Continued From page 24 tracheostomy care when a resident with a tracheostomy was admitted to the facility, but she had not had time to set up education with respiratory therapy since Resident #56 had been admitted. She stated she did not provide any education to nursing staff regarding emergency procedures in the event of a tracheostomy tube dislodgement because respiratory therapy personnel provided education on emergency tracheostomy care. The SDC Nurse stated she was not sure if an ambu bag and an obturator needed to be present or readily available in a resident room if the resident had a tracheostomy. Review of the facility's educational classes revealed respiratory therapy personnel last provided classes on tracheostomy care (how to clean a tracheostomy) and suctioning on 07/05/23, 07/06/23, and 07/07/23. There was no documentation that respiratory therapy personnel provided education on emergency procedures in the event of a tracheostomy tube dislodgement. An interview with the Infection Preventionist (IP) Nurse on 08/01/24 at 10:24 AM revealed she switched to the infection prevention role in March 2024. The IP Nurse stated she received education on cleaning and suctioning a tracheostomy but could not recall receiving any education since beginning employment on emergency procedures in the event of tracheostomy tube dislodgement. A telephone interview with the Respiratory Therapist (RT) on 08/01/24 at 11:35 AM revealed the facility usually notified him when they admitted a new resident with a tracheostomy and he or another respiratory therapist came to the facility and provided staff with additional education. He	F 726	tracheostomy by 8-26-24. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All licensed floor nurses employed at Carolina Rehab Center of Burke will be educated by the Director of Nursing (DON), Staff Development Coordinator (SDC), or designee on emergency supplies needed at bedside for tracheostomy residents. This education will be completed by 8/26/24. Licensed floor nursing staff not receiving education regarding tracheostomy care/emergency supplies at bedside will not be allowed to work until education is received. New licensed floor nursing staff will receive tracheostomy care/emergency supplies by bedside education within the orientation process by the staff development coordinator or designee. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The DON, SDC, or designee will audit to ensure all new licensed nursing staff receive education on tracheostomy care including emergency supplies to be at bedside 5 x weekly x 4 weeks, 3 x weekly x 4weeks, monthly x 1. The findings will be reviewed at the quarterly QAPI meetings to review progress. Date of compliance is 8/26/24. The Administrator is responsible for implementing the acceptable plan of correction.	

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F 726	Continued From page 25	F 726		

stated topics he reviewed with nursing staff included removing and replacing tracheostomy ties, removing the inner cannula (tube), cleaning the stoma (opening of the tracheostomy), suctioning, and the importance of always keeping an obturator and ambu bag at the bedside in the event of dislodgement. The RT stated he could not recall the exact date, but the last time he provided tracheostomy training for nursing staff was in July 2023.

A telephone interview with Nurse #1 on 08/01/24 at 12:07 PM revealed she had been employed at the facility since 2021 and she had received periodic education regarding tracheostomy suctioning and cleaning of the tracheostomy, but she could not recall receiving education on the importance of having an obturator readily available in the event of tracheostomy becoming dislodged. She stated an ambu bag was available on the code cart, which was kept at the nursing station.

An interview with Nurse #2 on 08/01/24 at 2:36 PM revealed she had been employed at the facility for 3 years. She stated from her previous employment at another facility she was used to residents with a tracheostomy always having an obturator and ambu bag at their bedside, but she had been informed at this facility as long as an ambu bag was available on the code cart that was fine. Nurse #2 stated she could not recall receiving any education from the facility regarding obturator use or storage.

An interview with Nurse #3 on 08/01/24 at 3:14 PM revealed she worked prn (as needed) at the facility, and she could not recall receiving any training from the facility regarding the procedure

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F 726	Continued From page 26 for tracheostomy dislodgement, including what supplies needed to be readily available. She stated the only education she received from the facility for residents with a tracheostomy was to make sure suction was available and to provide tracheostomy care at least once a shift. An interview with the Director of Nursing (DON) on 08/01/24 at 5:24 PM revealed every resident with a tracheostomy should have an obturator and ambu bag readily accessible to them in the event of an emergency. She stated she considered storing an ambu bag on the crash cart as being readily accessible and obturators were available in tracheostomy kits that were kept in the supply room. The DON stated if a resident with a tracheostomy did not have a tracheostomy kit in their room, nursing staff had access to the supply room. She stated education regarding tracheostomy care was provided as part of the orientation process for nursing staff and periodically when a new resident with a tracheostomy tube was admitted. The DON stated inner cannulas were available in Resident #56's room instead of an obturator and further education would be provided to nursing staff.	F 726		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		8/26/24

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F 812	Continued From page 27 (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 date and cover an open food item and discard food with signs of spoilage in 1 of 1 walk-in cooler; date an open beverage item and date milkshakes to identify their use-by date in 1 of 1 reach-in cooler; label and date open food items and discard expired beverages in 1 of 1 dry storage room; date an open food item in the food preparation area of 1 of 1 kitchen; and maintain clean refrigerators in 3 of 3 nourishment rooms (100/400 hall, 300 hall, and 200 hall). This failure had the potential to affect food served to residents. Findings included: 1. An initial tour of the walk-in cooler on 07/28/24 at 09:30 AM revealed the following: (a). a 3-pound bag of sliced ham that was undated and open to air (b). a box containing tomatoes with brown spots An interview with the Dietary Manager on 07/28/24 at 09:30 AM revealed all opened food items should be dated when they were opened and should be covered to prevent spoilage by the	F 812	F812 1. How corrective action will be accomplished for those residents found to have been affected: No residents were identified to have been affected by this deficient practice. The facility failed to date and cover an open food item and discard food with signs of spoilage in the walk-in cooler; date an open beverage item and date milkshakes to identify the use-by-date in the reach-in cooler; label and date open food items and discard expired beverages in dry storage room; date an open food item in the food preparation are of the kitchen; and maintain clean refrigerators in all nourishment rooms. All items identified that were not dated or expired were immediately thrown out . All nourishment room refrigerators were immediately cleaned. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: This alleged deficient practice had the potential to affect food served to	

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F 812	Continued From page 28 person placing the item in the cooler. She stated all dietary staff should be checking produce daily for spoilage and discard if needed. An interview with the Administrator on 08/01/24 at 06:00 PM revealed she expected dietary staff to follow their policy regarding dating food items, storing food, and discarding spoiled food items. 2. An observation of the reach-in cooler on 07/28/24 at 09:40 AM revealed the following: (a). an opened and undated 48-ounce bottle of prune juice (b). 9 fully thawed 4-ounce manufactured milkshakes with no label to indicate the date they were removed from the freezer or the expiration date An interview with the Dietary Manager on 07/28/24 at 09:40 AM revealed all opened beverage items should be dated when opened and manufactured milkshakes should have a date they were removed from the freezer. She stated staff who opened beverages were responsible for dating them at the time they were opened. The Dietary Manager stated staff who removed manufactured milkshakes from the freezer were responsible for dating the milkshakes and they were only good for 14 days after being thawed. An interview with the Administrator on 08/01/24 at 06:00 PM revealed she expected dietary staff to follow their policy regarding dating food items. 3. An observation of the dry storage room on 07/28/24 at 09:52 AM revealed the following: (a). 8 46-ounce boxes of honey thickened water	F 812	residents. On 7-29-24, the dietary manager and regional culinary manager completed a full 100% audit of all identified storage areas to ensure no additional items were noted and that all refrigerators were clean and sanitary. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All Dining Services employees were in-serviced between 8-16-24 and 8-26-24 regarding proper procedures for discarding expired food items and labeling and dating items, along with daily cleaning expectations for nourishment room refrigerators. A sanitation inspection will be conducted by Regional Culinary Manager or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened, and expectations for maintaining clean refrigerators in all areas. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained	

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F 812	Continued From page 29 with a use-by date of 07/18/24 (b). 1 46-ounce box of honey thickened apple juice with a use-by date of 07/03/24 (c). 2 46-ounce boxes of honey thickened apple juice with a use-by date of 05/30/24 (d). 1 46-ounce box of honey thickened tea with a use-by date of 07/05/24 (e). 1 opened and undated 10-pound bag of rice (f). 1 opened and undated 10-pound bag of elbow noodles An interview with the Dietary Manager on 07/28/24 at 09:52 AM revealed staff were responsible for dating items when they were opened and staff who stocked items in the dry storage room were responsible for checking for expired items and discarding them if needed. An interview with the Administrator on 08/01/24 at 06:00 PM revealed she expected dietary staff to follow their policy on dating items when opened and discarding expired items. 4. An observation of the food preparation area of the kitchen on 07/28/24 at 09:58 AM revealed an undated bin of sugar. An interview with the Dietary Manager on 07/28/24 at 09:58 AM revealed the bin of sugar should have an expiration date and she was not sure why it wasn't dated. An interview with the Administrator on 08/01/24 at 06:00 PM revealed she expected dietary staff to follow their policy on dating opened food items. 5. (a). An observation of the 100/400 hall nourishment room refrigerator on 08/01/24 at 12:40 PM revealed multiple dried stains to the	F 812	Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. 5. Completion date: 8-26-24	

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F 812	Continued From page 30 shelves and drawers of the refrigerator. (b). An observation of the 300 hall nourishment room refrigerator on 08/01/24 at 12:45 PM revealed multiple dried brown stains to the shelves of the door. (c). An observation of the 200 hall nourishment room refrigerator on 08/01/24 at 12:55 PM revealed multiple dried yellow stains to the shelves and door of the refrigerator. An interview with the Dietary Manager on 08/01/24 at 04:26 PM revealed dietary staff who stock nourishment rooms should clean the refrigerators as needed daily. An interview with the Administrator on 08/01/24 at 06:00 PM revealed she expected nourishment room refrigerators to be clean.	F 812		