STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 10/23/2024

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/20/24 through 10/23/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #WSLF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/20/24 through 10/23/24. Event ID# WSLF11. The following intakes were investigated NC00210740, NC00210995, NC00211503, NC00211771, NC00212614, NC00212842, NC00214171, NC00214348, NC00214845, NC00215272, NC00215240, NC00218815, NC00219261, NC00221643, NC00221740, NC00222001, NC00222285, NC00222464, NC00222469, NC00222913. 4 of the 58 complaint allegations resulted in a deficiency.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken),	F 583		11/15/24

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

Electronically Signed | 11/08/2024

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F 583	Continued From page 1 written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a resident's privacy by not providing full visual privacy during tracheostomy (hole that surgeons make through the front of the neck and into the windpipe) care for 1 of 1 resident (Resident #187) reviewed for personal privacy. The reasonable person concept was applied as a reasonable person would expect privacy in their home when being cared for. The findings included: Resident #187 was admitted to the facility on 10/7/2024. Review of the admission Minimum Data Set (MDS) assessment dated 10/13/2024 revealed he had severe cognitive impairment and was coded	F 583	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. F583 Personal privacy/ confidentiality of records 1. Nurses providing treatment educated at the time of the breach. 2. Current residents have the potential to be affected by this practice. 3. Current staff will be educated on personal privacy. Education will include	

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F 583	Continued From page 2 for tracheostomy care. During a continuous observation of tracheostomy care from inside Resident #187's room on 10/23/2024 from 11:00 AM until 11:18 AM, Nurse # 1 and Nurse # 2 left Resident #187's door open to the hallway while they were cleaning the tracheostomy site, performing suctioning, and changing the tracheostomy cannula. Resident #187 was in a private room and there was no privacy curtain in the room. While standing at Resident #187's bedside, observing Nurse #1 and Nurse #2 provide care for the resident the hallway could easily be visualized. There was nothing in the room that would obstruct the view of the resident receiving care from the hallway. An interview was completed on 10/23/2024 at 11:21 AM with Nurse # 1 where she reported Resident #187's door should have been closed for his privacy. Nurse # 1 went on to say she was not sure why she did not close the door except that she just forgot. During an interview with Nurse #2 on 10/23/2024 at 11:23 AM he reported the door to Resident #187's room should not have been opened while they were providing care, but he forgot to close it or even remind Nurse #1 to close it. An interview was conducted on 10/23/2024 at 11:32 AM with the Director of Nursing (DON) where she explained there were no privacy curtains in the private room, but she expected the resident's door to be closed any time care was being provided to maintain their privacy. On 10/23/2024 at 12:33 PM an interview was completed with the Administrator. During the	F 583	closing the door while providing care. Education will be provided by the SDC or designee. Education will be completed 11/14/2024. Any staff not receiving education by 11/14/2024 will not be allowed to work until education is received. Any new staff will be educated by the Director of nursing or designee during the orientation process. 4. The director of nursing or designee will audit 3 resident interactions for personal privacy during patients care. Audits will be 5x weekly x4 weeks, 3x weekly x4 weeks, 1xweekly x4 weeks. 5. Results will be reported by the Director of Nursing to the quality assurance meeting x1 month for further resolution as needed. 6. Date of completion : 11/15/2024	

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F 583	Continued From page 3 interview the Administrator reported she expected staff to close the door when providing care to maintain resident privacy.	F 583		
F 641 SS=D	Accuracy of Assessments 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 upon observation, record review, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1of 1 resident (Resident #187) reviewed for special services. Findings included: Resident #187 was admitted to the facility on 10/7/2024 with the following diagnoses: respiratory failure with hypoxia, pneumonia, and tracheostomy status. A review of Resident #187's admission Minimum Data Set (MDS) dated 10/13/2024 showed the resident had severe cognitive impairment, aphasia and respiratory failure. The MDS also revealed Resident #187 was receiving oxygen, needed tracheostomy care, and was on invasive mechanical ventilation. Review of Resident #187's care plan dated 10/18/2024 revealed he was at risk for complications secondary to a tracheostomy related to respiratory failure. Interventions included: tracheostomy care as needed, notify the Physician of any respiratory complications, and	F 641	F641 Assessment of assessments 1. Residents # 187 has been updated / revised to reflect their status. 2. All current resident□s Minimum Date Set assessments will be audited for accuracy in relation to Invasive Mechanical Ventilator coding. 3. Current Minimum Data Set team was educated by Region of Director of Clinical Services or designee regarding Minimum Data Set coding Accuracy for Section O. Education completed on 11/08/2024. Any new Minimum Data set nurse will be educated during the orientation process 4. 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 5. Results will be reported by the Minimum Data Set Nurse to the quality assurance meeting x1 month for further resolution as needed. 6. 11/15/2024	11/15/24

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F 641	Continued From page 4 suction as needed. There was no care plan for invasive mechanical ventilation. A review of Physician orders dated 10/7/2024 through 10/20/2024 revealed there were no orders for invasive mechanical ventilation. On 10/20/2024 at 2:21 PM Resident #187 was observed lying in bed, alert with eyes open. A tracheostomy was in place with oxygen running. There was no evidence of invasive mechanical ventilation. An interview was completed with Nurse #3 on 10/22/2024 at 2:22 PM. During the interview Nurse #3 looked at Resident #187's electronic medical record and reported while he was in the hospital he did receive invasive mechanical ventilation, but was weened down from the ventilator prior to admission to the facility.	F 641		
F 695 SS=D	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 reviews, and staff interviews, Nurse #1 failed to follow the procedure for tracheostomy (hole that surgeons make through the front of the neck and into the windpipe) care when she did not use the sterile	F 695	F695 Respiratory/ Tracheostomy care and suctioning 1. Oxygen orders placed in resident 187 medical record. Nurse #1 educated on sterile procedure on 10/20/2024 by the	11/15/24

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F 695	Continued From page 5 gloves from the sterile tracheostomy kit when cleaning the tracheostomy site and changing the inner canula. In addition, the facility failed to have a physician order for continuous oxygen for Resident #187. This deficient practice occurred for 1 of 1 resident requiring tracheostomy care (Resident #187). The findings included: a. Review of the facility's procedure guide for Tracheostomy Care read in part, perform hand hygiene and apply clean /sterile gloves for suctioning and other Personal Protective Equipment (PPE) if not already completed. Hyper-oxygenate resident for 30 seconds or ask resident to take 5-6 deep breaths then suction tracheostomy. Before removing gloves, remove the soiled dressing and discard. Perform hand hygiene again and prepare equipment on the bedside table as follows: Open sterile tracheostomy kit and prepare dressings and cleaning supplies. Open sterile tracheostomy dressing package. Unwrap sterile basin and pour normal saline into it. Open small sterile brush package and place aseptically into sterile basin. Prepare tracheostomy fixation device. Open inner cannula package. Apply sterile gloves and keep dominant hand sterile throughout procedure. Resident #187 was admitted on 10/7/2024 with the following diagnoses: respiratory failure with hypoxia, pneumonia and tracheostomy status. Review of orders dated 10/7/2024 showed the following, tracheostomy care every shift and as needed. Clean or change the inner cannula as applicable. Suction tracheostomy as needed for excess secretions.	F 695	Staff development Coordinator. An Audit of current residents with oxygen was completed on 10/20/2024 and all residents with oxygen have current oxygen orders in place. 2. Current licensed nursing staff will be educated in ensuring that orders are transcribed when oxygen is initiated. Education will be conducted by the Director of Nursing or designee. Education will be completed by 11/14/2024. Current licensed nurses will be educated in tracheostomy care including sterile procedure and a skill competency completed for tracheostomy care including sterile procedure will be completed by current licensed nurses. This will be completed by 11/14/2024 by the Director of Nursing or designee. Any licensed nurse not receiving the education and skill competency will not be allowed to work until completed. Any Licensed Nurses will receive education and have a skill competency completed during the orientation process. 3. Director or Nursing or designee will audit current patients with oxygen to ensure orders are in place 3xweekly x4 weeks, 1xweek x 8 weeks. All new admissions will be audited for Oxygen orders in daily clinical meetings. Director of Nursing or designee will observe tracheostomy care 3x weekly x 4 weeks and weekly x 8 weeks to ensure sterile procedures are followed. 4. Results will be reported by the Director of Nursing to the quality assurance meeting x1 month for further resolution as needed.	

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F 695	Continued From page 6 A review of the admission Minimum Data Set (MDS) assessment dated 10/13/2024 revealed Resident #187 had severe cognitive impairment and required tracheostomy care. Review of the care plan dated 10/18/2024 showed a problem that the Resident was at risk for complications secondary to a tracheostomy related to respiratory failure. There was a goal for the Resident to be free from complications related to having a tracheostomy. Interventions included, observe for signs and symptoms of respiratory complications including infection and or respiratory blockage or mucous plug, refer to pulmonologist as needed, suction as needed, and tracheostomy care per order. A continuous observation of tracheostomy care was conducted on 10/23/2024 from 11:00 AM to 11:21 AM. Before the procedure, Nurse #1 performed hand hygiene and applied gloves. Nurse #1 proceeded to open the sterile tracheostomy cleaning kit and while opening the kit an item fell to the floor. Nurse #1 retrieved another tracheotomy cleaning kit from the PPE container hanging on the Resident's door. Nurse #1 failed to remove gloves, perform hand hygiene, or apply new gloves before continuing to open the rest of the items in the tracheostomy kit. Prior to cleaning the tracheostomy site and changing the inner cannula, Nurse #1 failed to apply the sterile gloves from the tracheostomy kit or keep one hand sterile through the procedure. An interview was completed on 10/23/24 at 11:22 AM with Nurse #1. During the interview Nurse #1 stated the sterile gloves should have been applied and changed anytime the sterile field was broken.	F 695	5. 11/15/2024	

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F 695	Continued From page 7	F 695		

During an interview on 10/23/24 at 11:32 AM with the Director of Nursing (DON) she reported she expected Nurse #1 to follow the policy and procedures, including using the sterile gloves provided in the tracheostomy kit when performing tracheostomy care.

On 10/23/24 at 12:06 PM an interview was completed with the Infection Preventionist (IP). During the interview the IP stated Nurse #1 should have followed the policy and procedure for tracheostomy care as well as changed her gloves and washed her hands after getting a new tracheostomy cleaning kit. The IP further explained there would be additional education on proper tracheostomy care and hand hygiene.

An interview was completed with the Administrator on 10/23/24 at 12:33 PM where she reported she expected staff to follow policies and procedures for tracheostomy care.

b. A review of Resident #187's physician orders dated 10/7/2024 through 10/21/2024 revealed orders were in place for tracheostomy care. There were no orders for oxygen use.

An observation on 10/20/2024 at 2:21 PM showed Resident #187 was lying in bed with oxygen set to 3 liters (L)/minute.
On 10/22/2024 at 8:53 AM Resident #187 was observed lying in bed with oxygen flowing into the tracheostomy and set on 3L/minute.

An interview was completed on 10/22/2024 at 2:22 PM with Nurse #3. During the interview Nurse #3 looked at Resident #187's orders and was unable to find any orders related to oxygen flow rate, however she was able to find the

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F 695	Continued From page 8 oxygen settings in Resident #187's discharge paperwork. Nurse #3 went on to say if there was no order in place the Nurse Practitioner (NP) or Physician needed to be called for clarification orders. During an interview with the 200 Hall Unit Manager on 10/22/2024 at 2:32 PM she looked at the Physician orders and electronic medical record (eMAR) for Resident #187 and was not able to find orders for oxygen use. The Unit Manager stated there should have been orders in place for the oxygen flow rate. An interview was completed with the Director of Nursing (DON) on 10/22/2024 at 2:43 PM. During the interview the DON looked through Resident #187's eMAR and was not able to find orders for oxygen use, including flow rate. The DON reported there should be orders in the system for oxygen flow rate and the humidifier on the O2 concentrator. The DON further explained Resident #187 was a newly admitted resident and new admission orders were reviewed by several members of the nursing team, including the Unit Managers, but somehow the orders for Resident #187's oxygen had been missed. During an interview with the Administrator on 10/23/2024 at 12:33 PM she reported her expectation was for all orders for any newly admitted residents to be discussed during clinical meetings and any discrepancies needed to be discussed and the Physician notified. The Administrator went on to say there should have been orders in place for Resident #187's oxygen.	F 695		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		11/15/24

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F 803	Continued From page 9 §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of Resident Council minutes, and resident and staff interviews, the facility failed to follow their planned menus for 1 of 1 sampled resident reviewed for preferences (Resident #65). The deficient practice had the potential to affect other residents who received food from the kitchen. The findings included:	F 803	F803 Menus meet residents need/ Prep in advance/ followed 1. Dietary Manager was educated on posting a sign next to the posted menu, when there are substitutions that need to be made to make residents aware of the changes. Dietary staff educated on the importance of following meal tickets on the tray line. 2. Current residents have the potential	

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F 803	Continued From page 10 Resident #65 was admitted to the facility on 7/30/2024, discharged and readmitted on 10/8/2024 with the following diagnoses: end stage renal disease (ESRD), dependence upon dialysis, vitamin deficiency, and gastroesophageal reflux disease (GERD). A review of the admission Minimum Data Set (MDS) dated 8/5/2024 revealed that Resident #65 was cognitively intact. The MDS also indicated Resident #65 only needed set-up assistance from staff with eating. Review of #65's Physician orders dated 10/8/2024 showed a dietary order for a renal diet with regular texture and thin liquids. A review of Resident #65's most recent care plan dated 8/16/2024 revealed Resident #65 was at risk for weight loss or malnutrition related to chronic diseases including GERD, ESRD, and dependence upon dialysis. The goal in place was for Resident #65 to have optimal nutrition and hydration status through the review period. Interventions included therapeutic diet as ordered, encourage to eat, and monitor meal intakes. Review of Resident Council minutes dated 5/7/2024 showed residents did not feel like the menus were being followed and they were not receiving what they ordered. An additional review of Resident Council minutes dated 7/3/2024 revealed residents were concerned that they were not being informed when substitutions were being made to meals. Resident Council notes dated 8/13/2024 indicated	F 803	to be affected by this practice. 3. Dietary staff will be educated by the Dietary Manager by 11/14/2024 on contacting the dietary manager when substitutions need to be made after hours or over the weekend. Dietary Manager will be educated to notify Regional Dietary Manager and Administrator when substitutions need to be made by 11/14/2024 Weekend cooks will be assigned to post any substitutions made during the weekend. All current resident□s food preferences are being updated by the Dietary Manager and Regional Dieticians 11/14/2024 Dietary staff will be educated on how to read a tray card as well as making sure that what is selected on the trey cards is what is being placed on residents trays by the dietary manager or designee by 11/14/2024 Any Dietary employee who has not received education will not be allowed to work until education has been completed. New Dietary staff will be educated during the orientation process. 4. Dietary Manager or Designee will audit the scheduled menu and stored food items to ensure we have what is supposed to be served to the residents. Audits will be 5x weekly x4 weeks, 3x weekly x 4 weeks, 1xweekly x4 week. Dietary Manager or designee will audit residents tray card to ensure what is on the tray is accurate to what is on their tray card. Audits will be 5x weekly 4 weeks, 3xweekly x4 weeks, 1xweekly x4 weeks. 5. Results will be reported by the Dietary Manager to the quality assurance meeting	

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F 803	Continued From page 11 residents were concerned because they were not getting what they were selecting on their menus. On 10/20/2024 at 10:40 AM an interview was completed with a Cook Aide where she reported food was delivered on Mondays and sometimes the facility received what they ordered and sometimes they did not. She went on to say the Dietary Manager placed the orders and then someone above her changed the order due to the budget. An interview with Resident #65 on 10/20/2024 at 12:23 PM revealed meal tickets did not usually match what was served. The interview further revealed Resident #65 felt as if she did not ever receive enough protein as she rarely received any meat at breakfast. Resident #65 went on to say she was not always offered the chance to make choices regarding the menu, because staff would serve what they wanted to serve. An observation of Resident #65's lunch tray on 10/20/2024 at 12:27 PM showed she had mixed greens, black eyed peas, a meat that the resident reported as baked chicken, and pineapple tidbits. An observation of Resident #65's lunch meal ticket indicated she should have received buttered green beans, black eyed peas, baked chicken, and apple pie. An additional observation was completed on 10/22/2024 at 8:45 AM of Resident #65's meal ticket and breakfast tray. Resident #65's tray had oatmeal and scrambled eggs. A review of the meal ticket revealed there should have also been a sausage patty and a cup of milk on the tray. Resident #65 reported she received neither of those items.	F 803	x1 month for further resolution as needed. 6. Date of completion: 11/15/2024	

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	345405	A. BUILDING _____ B. WING _____	C 10/23/2024

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F 803	Continued From page 12	F 803		

An observation of the breakfast menu outside of the dining room on 10/23/2024 at 8:27 AM showed there was supposed to be a sausage patty with biscuit and country gravy and a side of grits.

Observation and interview of Resident #65's breakfast meal ticket on 10/23/2024 at 8:30 AM revealed the resident had received eggs, toast, and cereal. Resident #65 reported she did not receive a sausage patty or gravy for breakfast.

During an interview on 10/22/2024 at 10:39 AM with Nurse Aide (NA) #1 she explained resident menus were supposed to be filled out the day before and the only time they were informed of any changes in the menu was when they would open the resident's meal tray during set-up.

An interview was completed on 10/22/2024 at 10:59 AM with NA #2 where she reported staff would not be told about any menu changes and would learn about the changes when the meal tray was opened. NA #2 further explained that some residents would receive breakfast meats, and others would not because the kitchen did not always have protein available.

An interview with the Registered Dietician (RD) was completed on 10/22/2024 at 8:59 AM. During the interview the RD reported she signed off on a log after the fact for any substitutions. She went on to say the Dietary Manager was able to make the substitutions if the kitchen was out of what they were supposed to have. The RD also reported any substitutions that were made to the menu had to be posted outside of the dining room. The RD further explained the kitchen did

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F 803	Continued From page 13 not have anything that could have been substituted for the sausage because the company that delivered the food order was out of sausage. An interview was conducted on 10/22/2024 at 9:28 AM with the Dietary Manager. During the interview the Dietary Manager reported the meal tickets were not changed to show substitutions and the only way a resident would know if there had been a change would be for them to come to the dining room to look at the menu. An interview was completed on 10/23/2024 at 12:35 AM with the Administrator where she explained her expectations were that the residents be informed of any menu changes and the kitchen to follow their policies and procedures.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		11/15/24

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F 812	Continued From page 14 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to label and date leftover food items stored for use, keep a food storage area clean and orderly, and failed to dry serving trays prior to stacking. These practices occurred in 1 of 7 reach-in coolers, 1 of 1 walk-in freezer, 1 of 1 dry goods storage area, and had the potential to affect food served to residents. The findings included: An initial tour of the main kitchen occurred 10/20/24 at 10:26 AM. The following concerns were identified: a. A bag of leftover frozen French fries was observed in the walk-in freezer not dated. b. Food items in the reach-in coolers that were open and not labeled with a use by date included: -three resealable plastic bags of cut watermelon -one gallon tub of sweet pickle relish -gallon tub of blue cheese dressing -five-pound tub of sour cream -14 ounce can of whipped cream c. Four disposable bowls of vanilla pudding on a tray, not covered or dated in the reach-in cooler were observed. d. Three bags of hamburger buns with manufacturer's best by of 9/14/24 were observed in the dry storage room. e. 51 clean serving trays were observed	F 812	F812 Food procurement- store/ prepare/ serve 1. The facility failed to date and store food items properly. Undated and improperly stored items were discarded on 10/20/2024. Serving trays were moved to dry area on 10/20/2024. Dietary staff educated on the food storage policy including drying storage trays prior to storage 10/20/2024 by the dietary manager. 2. Current residents have the potential to be affected by this practice. 3. Dietary staff will be educated on how to properly date food items for storage . Education includes keeping food clean and orderly and ensuring serving trays are dry prior to stacking. 4. Education on the food storage policy will be completed with the dietary team the dietary manager or designee by 11/14/2024. Education will also include drying serving trays prior to storage. The dietary manager will complete daily rounds to ensure that all expired food are discarded and serving trays are dry when stored. Weekend cooks will be assigned to discard any expired food items on the date the food expires. The dietary manager will report any concerns to the regional dietary manager, the administrator, and the Quality Assurance team. Any Dietary employee who has not received education will not be allowed to	

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F 812	Continued From page 15 wet-nested in the dishwashing area on a tray-holding cart. All 51 trays were visibly wet and wet to the touch. An interview with Cook Aide #1 on 10/20/24 at 10:40 AM revealed the trays were stacked wet due to limited space in the dishwashing area. An interview with the Dietary Manager (DM) on 10/22/24 at 9:28 AM revealed she had been in the DM role for about a month. She stated she was not aware of the wet nested trays, the items that were not labeled, and items stored past the use by date. An interview with the Administrator on 10/23/24 at 12:35 PM revealed she had the expectation that the kitchen staff and managers followed their policies and procedures.	F 812	work until education has been completed. Any new Dietary employee will receive education during the orientation process. 5. Results will be reported by the Dietary manager to the quality assurance meeting x1 month for further resolution as needed. 6. 11/15/2024	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove loose garbage, food, and debris from around 2 of 2 trash receptacles located outdoors behind the kitchen. This practice had the potential to impact sanitary conditions and attract pests/rodents. The findings included: An observation of the outdoor trash receptacle area on 10/20/24 at 10:52 AM revealed eight sets of used disposable gloves and one used	F 814	F814 Dispose garbage and refuse properly 1. Garbage was properly disposed of in the dumpster. 2. Current residents have the potential to be affected by this practice. 3. Current Dietary staff will be educated on how to properly dispose of trash in the appropriate receptacles by the dietary manager or designee by 11/15/2024. The Dietary Manager will be educated on checking the dumpster area 2x daily to	11/15/24

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F 814	Continued From page 16 sandwich bag with food debris in it on the ground outside of the receptable. One garbage bag was found on the sidewalk leading to the trash receptacle area that was open with debris and spaghetti noodles. During the observation the receptacle door on one trash receptacle was noted to be open and the lid of the trash receptacle caved into the dumpster, weighed down by garbage bags. An interview with Maintenance Assistant on 10/22/24 09:28 AM revealed the housekeeping and maintenance departments were responsible for keeping the trash receptacle area clean. He stated the area was cleaned each morning and trash and debris was removed from night shift. An interview with the Administrator on 10/23/24 at 12:35 PM revealed she expected the trash receptacle area to be maintained according to the facility's policies and procedures.	F 814	ensure the area is free from debris and food waste by the regional dietary Manager by 11/15/2024. Weekend staff will be assigned to check the dumpster area 2x daily. Any Dietary employee who has not received education will not be allowed to work until education has been completed. Any new Dietary employee will receive education during the orientation process. 4. The dietary Manager of Designee will audit the dumpster area for any debris or food waste. Audits will be completed 5x weekly x4 weeks, 3x weekly x4 weeks, 1x weekly x1 week. 5. Results will be reported by the Dietary Manager to the quality assurance meeting x1 month for further resolution as needed. 6. Date of completion: 11/15/2024	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the food steamer, which leaked water onto the floor in the main kitchen, in safe operating condition. Findings included: An observation made on 10/20/24 at 10:43 AM revealed a large puddle of water under the food	F 908	F908 Essential equipment, safe operating conditions 1. The Maintenance Director added piping to the bottom of the steam table to connect the table to the drain on 10/20/2024 2. Current residents have the potential to be affected by this practice. 3. Dietary staff will be educated on	11/15/24

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F 908	Continued From page 17 steamer next to the gas stove adjacent to the food preparation area. Water was observed dripping out a plastic pipe on the back of the appliance. The pipe was not located above the floor drain and a large puddle of water was observed on the kitchen floor. An interview with Cook Aide #1 on 10/20/24 at 10:42 AM revealed the kitchen staff verbally reported the leaking pipe from the food steamer to Maintenance staff multiple times in the previous weeks and the water was still leaking on the kitchen floor. An interview with Dietary Manager (DM) on 10/22/24 at 9:28 AM revealed she was not aware of the leaking pipe from the food steamer. An interview with the Maintenance Assistant on 10/23/24 at 9:48 AM revealed he was not aware of the leaking pipe from the food steamer. He stated the facility used an online maintenance tracking system. He stated staff knew to enter a concern in the system, and Maintenance staff would respond to the need. He stated if there was an urgent need, staff knew to verbally alert the Maintenance staff, and they would immediately respond. An interview with the Administrator on 10/23/24 at 12:35 PM revealed she was not aware of the leaking pipe under the steamer appliance, and she had the expectation that the kitchen staff and managers followed their policies and procedures to maintain equipment and report any concerns to Maintenance staff.	F 908	notifying maintenance of any leaks by dietary manager or designee by 11/15/2024. Maintenance will be educated on fixing the steam table in a timely manner by the administrator by 11/15/2024. 4. The maintenance director or designee will audit the steam table 3x weekly x4 weeks, 2x weekly x4 weeks, 1xweekly x4 weeks 5. Results will be reported by the Maintenance Director to the quality assurance meeting x1 month for further resolution as needed. 6. Date of completion: 11/15/2024	