STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345384	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-FARMVILLE	4351 SOUTH MAIN STREET , FARMVILLE, North Carolina, 27828

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/4/25 through 8/7/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D25C2-H1.	E0000		08/21/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/4/25 through 8/7/25. Event ID# 1D25C2-H1. The following intake was investigated: 2570898. 1 of the 2 complaint allegations resulted in deficiency.	F0000		08/21/2025
F0559 SS = A	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff and the Responsible Party (an individual who may be required to assume certain obligations related to the care and finances of a cognitively impaired resident), the facility failed to notify the Responsible Party of a cognitively impaired resident that the resident was getting a new roommate for 1 of 1 resident reviewed for notification of a new roommate (Resident #32). Findings included:	F0559		08/21/2025

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

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

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F0559 SS = A	Continued from page 1 Resident #32 was admitted to the facility on 10/27/20. Review of Resident #32's Minimum Data Set assessment dated 6/19/25 revealed she was assessed as severely cognitively impaired. Review of Resident #32's face sheet on 8/7/25 at 6:02 AM revealed Resident #32 had a Responsible Party (RP). During an interview on 8/4/25 at 10:31 AM Resident #32's RP stated she was not notified when Resident #32 received a new roommate, and she did not know when the new roommate arrived because they did not inform her. She stated she was the RP and should be notified if Resident #32 had a new roommate or roommate change. She discovered Resident #32 had a new roommate when she visited her family member in July 2025. During an interview on 8/6/25 at 8:55 AM the Social Worker stated the facility notified residents of a new roommate as soon as practicable when they knew the resident was getting a new roommate. As a courtesy, the family or RP was notified of the new roommate, but she was unsure if it was a regulation that the RP be notified of a new roommate. She stated she worked a half-day the day the roommate was admitted on 7/4/25, and she did not notify the RP of Resident #32 receiving a new roommate. During an interview on 8/6/25 at 11:14 AM the Administrator stated the RP should have been notified as soon as it was practicable of Resident #32's new roommate due to Resident #32 being severely cognitively impaired.	F0559		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify	F0641	Corrective Action for the Resident Affected On 08/05/25, Resident #4, Minimum Data Set, (MDS) assessment was modified for the Pre-Admission Screening and Resident Review, (PASARR), level II, in Section A, by the MDS Nurse. On 08/06/25, Resident #21, MDS assessment was modified for oral care in Section L, by the MDS nurse. Action for the Residents Potentially Affected On 08/05/2025, the total census in the facility was 52, on 08/05/2025, the MDS Nurse and the Social Worker reviewed all PASARR's. Of the remaining 51 Residents, all PASARR's were coded correctly in Section A of the MDS.	08/21/2025

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F0641 SS = D	Continued from page 2 that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Pre-Admission Screening and Resident Review (PASARR) status and failed to accurately code the Minimum Data Set (MDS) assessment in the area of oral/dental status for 2 of 15 resident MDS assessments reviewed (Resident #4, Resident #21). Findings included: 1. Resident #4 was admitted to the facility on 11/26/24. Her active diagnoses included schizophrenia, major depressive disorder, and anxiety disorder. Review of Resident #4's PASARR Level II Determination Notification letter dated 4/29/21 revealed it had no end date. Review of Resident #4's Minimum Data Set (MDS) assessment dated 12/6/24 revealed she was coded as not currently considered by the state PASARR Level II process to have a serious mental illness. During an interview on 8/5/25 at 11:29 AM the Social Worker stated Resident #4 had a PASARR Level II determination with no end date. During an interview on 8/5/25 at 11:50 AM the MDS	F0641	Continued from page 2 On 08/07/2025, the total census in the facility was 51, on 08/07/2025, the MDS Nurse reviewed Section L, of the MDS. Of the remaining 50 Residents, Section L was coded correctly on the MDS. Systemic Changes On 08/05/2025, the Senior Nurse Consultant in-serviced the Administrator, Social Worker, and MDS Nurse, on proper coding of Section A, PASARR's of the MDS, and accuracy of assessments. Any newly hired staff in these positions will receive the in-service during the orientation process. On 08/05/2025, the Senior Nurse Consultant, in-serviced the Administrator, Director of Healthcare Services (DHS), and MDS Nurse on accurately coding Section L, Oral Care, on the MDS and accuracy of assessments. Any newly hired staff in these positions will receive the in-service during the orientation process. Quality Assurance The Administrator will review for accuracy, Section A, PASARR of the MDS, for 2 assessments per week x4 weeks and then 3 assessments per month for 3 months, then 1 assessment monthly, utilizing the QA Monitoring Tool for Accuracy of Assessments, Section A. The results of the MDS accuracy reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator for review by the Interdisciplinary Team members monthly. Quality monitoring schedule modified based on findings. The Administrator will review for accuracy, Section L, of the MDS, for 2 assessments per week x4 weeks and then 3 assessments per month for 3 months, then 1 assessment monthly, utilizing the QA Monitoring Tool for Accuracy of Assessments, Section L. The results of the MDS accuracy reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator for review by the Interdisciplinary Team members monthly. Quality monitoring schedule modified based on findings. Date of compliance: 08/21/2025	

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F0641 SS = D	Continued from page 3 Coordinator stated the 12/6/24 MDS assessment for Resident #4 was incorrect. She concluded it was an oversite that would be corrected. During an interview on 8/5/25 at 11:55 AM the Administrator stated MDS assessments should accurately reflect the resident's PASARR status. 2. Resident #21 was admitted to the facility on 11/1/24. A review of Resident #21's nursing Admission Observation form dated 11/1/24 at 4:26 PM completed by Nurse #1 revealed documentation that Resident #21 had obvious or likely cavity or broken natural teeth. Attempts for an interview with Nurse #1 were unsuccessful. A review of Resident #21's admission Minimum Data Set (MDS) assessment dated 11/11/24 revealed he was severely cognitively impaired. He had no dental issues. The dental care area was not triggered. The dental care planning decision was not checked. On 8/5/25 at 8:14 AM Resident #21 was observed to have three front bottom teeth broken at the gumline and blackened in color, and one darkened discolored front bottom tooth. An interview with Resident #21 at that time indicated he had no dental pain, or trouble eating. On 8/6/25 at 10:23 AM a telephone interview with Dietary Manager #2 indicated she coded the oral/dental section of Resident #21's MDS assessment dated 11/11/24. She reported she did not recall observing Resident #21's teeth for completion of the assessment, but she recalled asking him if he had any dental issues and he denied any. She went on to say while the nursing Admission Assessment form would be something she reviewed to assist with completion of the oral/dental section of the MDS assessment, she could not recall whether or not she had done this for Resident #21's MDS assessment dated 11/11/24. On 8/6/25 at 10:44 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #21. She reported Resident #21 had broken and discolored teeth since his admission to the facility. She stated this was documented on his nursing Admission Observation dated 11/1/24. The DON stated Resident #21's admission MDS assessment should have been coded to accurately reflect this.	F0641		

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F0641 SS = D	Continued from page 4 On8/6/25 at 1:32 PM an interview with the Administrator indicated Resident #21's admission MDS assessment dated 11/11/24 should have been coded to accurately reflect his oral/dental status.	F0641		
F0656 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 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.	F0656	Corrective Action for the Resident Affected On 08/07/2025, Resident # 21, comprehensive care plan was reviewed for accuracy of interventions in place, reviewed by the MDS Nurse, for the floor mat, and floor mat was placed on right side of bed while resident was in bed. Action for the Residents Potentially Affected On 08/12/2025, the MDS Nurse, Director of Health Services, and Administrator reviewed comprehensive care plans for Residents with floor mats. Of the 51 Residents in the facility, 5 Residents had floor mats that were care planned and in their rooms. Systemic Changes On 08/07/2025, the Senior Nurse Consultant, (SNC), in-serviced the Administrator and MDS Nurse on completing a comprehensive care plan utilizing the company policy and ensuring interventions are in place, assigning intervention to resident profile, and where to find intervention in Matix care for proper interventions relating to care plan. On 08/08/2025, the Administrator in-serviced the Director of Healthcare Services, (DHS), on completing a comprehensive care plan utilizing the company policy and ensuring interventions are in place, assigning intervention to resident profile, and where to find intervention in Matix care for proper interventions relating to care plan. On 08/08/2025 Administrator in serviced IDT teams on completing a comprehensive care plan utilizing the company policy and ensuring interventions are in place, assigning intervention to resident profile, and where to find intervention in Matix care for proper interventions relating to care plan, to be observed during room rounds. On 08/07/2025 DHS began in-service with clinical staff of where to locate interventions in Matix care on resident profile for interventions relating to care plan. Any staff that are not in-serviced by the compliance date will receive the in-service prior to their next shift worked. Any newly hired staff in these positions will receive the in-service during	08/21/2025

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F0656 SS = D	Continued from page 5 §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 observations, record review, and staff interviews, the facility failed to implement the care planned intervention of a fall mat for 1 of 2 residents (Resident #21) reviewed for accidents. Findings included: Resident #21 was admitted to the facility on 11/1/24 with a diagnosis of dementia. A review of Resident #21's comprehensive care plan revealed a focus area initiated on 11/1/24 and last reviewed on 8/4/25 of at risk for falls related to senile dementia of the brain. The goal was for Resident #21 to not sustain any injury related to falling through the next review. An intervention, dated 6/6/25, was fall mat beside bed right side. A review of Resident #21's quarterly Minimum Data Set (MDS) assessment dated 7/21/25 revealed he was severely cognitively impaired. He had no functional limitation in range of motion of his upper or lower extremities. He used a wheelchair for mobility. He required supervision to roll left and right in bed, to go from sitting on the side of the bed to lying flat and to go from lying flat on the bed to sitting. Resident #21 required partial assistance to go from sitting to standing and to transfer from bed to chair. He had no falls since his prior assessment. On 8/6/25 at 8:04 AM Resident #21 was observed lying on his bed which was in a low position. No fall mat was observed on the right side of his bed or in his room. On 8/7/25 at 5:05 AM Resident #21 was observed lying on his bed which was in a low position. No fall mat was observed on the right side of his bed or in his room. On 8/7/2025 at 5:08 AM an interview with Nurse Aide (NA) #1 indicated she cared for Resident #21 regularly on the 11PM-7AM shift and was caring for him now. She reported she was familiar with Resident #21. NA #1 stated Resident #21 was at risk for falls. She stated at one time Resident #21 did have a fall mat in place, but he did not have one last night. She indicated she	F0656	Continued from page 5 orientation. Quality Assurance The Administrator and/or DHS will review 2 comprehensive care plans weekly x's 4 weeks, then 1 comprehensive care plan assessment monthly ensuring the development and completion of the Develop/Implement Comprehensive Care Plan is accurate, and interventions and are triggering on resident profile utilizing the QA Monitoring Tool for Comprehensive Care plans. The results of these QA Monitoring Tool reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or DHS for review by the Interdisciplinary Team monthly. Quality monitoring schedule modified based on findings. Date of compliance: 08/21/2025	

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F0656 SS = D	Continued from page 6 could not recall when she last saw a fall mat beside Resident #21's bed. She reported she did have access to residents' care plans. NA #1 stated the way she knew if a resident should have a fall mat while they were in bed was she would visually see it in the room. She stated that she didn't normally review the care plan for those residents she was familiar with but did for new residents. On 8/7/2025 at 5:18 AM an interview with Nurse #2 indicated she cared for Resident #21 on the 11PM-7AM shift and was familiar with him. She reported she knew at one point Resident #21 did have a fall mat at his bedside, but she hadn't seen one lately. Nurse #2 stated when she first noticed Resident #21's fall mat was not in place, she should have looked into the matter to determine whether it had been discontinued but she had not. On 8/7/25 at 7:26 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #21. She reported he was at risk for falls. She indicated the intervention of a fall mat beside bed right side which appeared on Resident #21's comprehensive care plan was still a current appropriate intervention, and this fall mat should have been in place. The DON stated ensuring care planned fall interventions were in place was a team effort. On 8/7/25 at 8:35 AM an interview with the Administrator indicated if a fall prevention intervention appeared on a resident's care plan, it should be in place.	F0656		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident:	F0791	Corrective Action for the Resident Affected On 08/06/2025, Resident # 21, dental services were offered, and the responsible party was notified. Appointment made for 08/22/2025. Action for the Residents Potentially Affected On 08/06/2025, the total census in the facility was 50, on 08/06/2025, the Social Worker reviewed the dental consents and compared them with the facility's contracted vendor, 360Care. Of the 50 Residents, 14 Residents were identified as needing a consent or declination. 7 Residents refused to sign up for dental services and 7 Residents signed up for the program. All consents have been sent to 360Care to update the resident roster and will be added to the next clinic. Systemic Changes	08/21/2025

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F0791 SS = D	Continued from page 7 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and resident, staff, and Responsible Party (RP) interviews the facility failed to provide or obtain routine dental services for a resident with obvious or likely cavity and broken natural teeth. This was for 1 of 1 resident (Resident #21) reviewed for dental care. Findings included: Resident #21 was admitted to the facility on 11/1/24 with a diagnosis of dementia. A review of a physician's order for Resident #21 dated 11/1/24 revealed in part "May have dental care as needed".	F0791	Continued from page 7 On 08/06/2025, the Administrator in-serviced the Social Worker on dental services, specifically the importance of discussing the dental program with the residents, ensuring that they, and or the Responsible Party has reviewed and signed the dental consent or declination form. If a declination form is signed, the Social Worker will document the Residents declination for routine services/emergencies in their chart and attach in residents' record. Quality Assurance The Administrator and or Director of Healthcare Services, (DHS), will audit all new admissions weekly times 4 weeks, then 2 admissions monthly to ensure that they were offered dental services from the facility's contracted vendor and or that they have a dentist for routine dental services/emergencies. The results of these QA Monitoring Tool Reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator and or DHS for review by the Interdisciplinary Team monthly. Quality monitoring schedule modified based on findings. Date of compliance: 08/21/2025	

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F0791 SS = D	Continued from page 8 A review of Resident #21's nursing Admission Observation form dated 11/1/24 at 4:26 PM completed by Nurse #1 revealed documentation that Resident #21 had obvious or likely cavity or broken natural teeth. Attempts at telephone interview with Nurse #1 were unsuccessful. A review of Resident #21's comprehensive care plan revealed a focus area dated as initiated on 11/1/24 and last revised on 7/18/25 for alteration in dentition. The goal was to maximize Resident #21's dentition and resolve to maximize independence through the next review. An intervention was dental consult as needed. A review of Resident #21's admission Minimum Data Set (MDS) assessment dated 11/11/24 revealed he was severely cognitively impaired. He had no dental issues. The dental care area was not triggered. The dental care planning decision was not checked. On 8/5/25 at 8:14 AM Resident #21 was observed to have three front bottom teeth broken at the gumline and blackened in color, and one darkened discolored front bottom tooth. An interview with Resident #21 at that time indicated he had no dental pain, or trouble eating. A review of Resident #21's facility medical record on 8/5/25 did not reveal any evidence of dental care since his admission to the facility. On 8/6/25 at 2:08 PM a telephone interview with the Responsible Party (RP) listed as the #1 contact on Resident #21's facility medical record face sheet indicated Resident #21 had fragmented and discolored teeth prior to his admission to the facility. She reported Resident #21 had never complained of any dental pain that she was aware of. She stated she did not recall anyone at the facility ever speaking with her about Resident #21's dental issues or informing her of any available dental care options. On 8/5/25 at 1:58 PM a telephone interview with the RP listed as #2 on Resident #21's facility medical record face sheet indicated she visited Resident #21 at least every other day at the facility. She reported that Resident #21 had fragmented and discolored teeth prior to his admission to the facility. She indicated Resident #21 had never complained of any dental pain that she was aware of. She stated she participated in Resident #21's care plan meetings when she was able to. RP #2 reported that she did not recall anyone at the	F0791		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-FARMVILLE	4351 SOUTH MAIN STREET , FARMVILLE, North Carolina, 27828

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F0791 SS = D	Continued from page 9 facility ever speaking with her about Resident #21's dental issues or informing her of any available dental care options. On 8/6/25 at 2:14 PM an interview with Resident #21 indicated he used to have a dentist that he visited before he came to live at the facility. He reported he had last seen a dentist about two or three years ago. He stated he did not recall anyone at the facility ever offering him any dental care options. Resident #21 indicated he would like to see a dentist if one was available to him. On 8/6/25 at 10:44 AM an interview with the Director of Nursing (DON) indicated she was familiar with Resident #21. She reported Resident #21 had broken and discolored teeth since his admission but had never complained of any dental pain. She stated if the admitting nurse documented dental issues on the nursing admission assessment, typically nursing would ensure this was reflected on the resident's care plan. The DON reported for any acute dental issues like pain, she would ensure that the resident's dental need was addressed. She went on to say the facility had an inhouse dental provider that came to the facility quarterly (every 3 months) for routine dental care, and she thought the Social Work (SW) handled that. On 8/6/25 at 1:00 PM an interview with the facility's SW indicated Resident #21 was a long term resident at the facility. She reported his payor source was Medicaid. She stated normally a resident's dental care was something that would be addressed during the interdisciplinary team (IDT) process. The SW reported the facility had an inhouse dental provider that saw residents who were on the list quarterly. She stated the dental hygienist had last been at the facility in May 2025, but Resident #21 had not been seen then. She indicated she had not been responsible for adding residents to the list to be seen by the dental provider. She reported she thought the Administrator was working on getting a list together for the next dental visit. On 8/6/25 at 2:24 PM an interview with the Administrator indicated there was no documentation in Resident #21's medical record that he had been offered dental care on admission to the facility or had received dental care in the facility since his admission. She reported Resident #21 was not on the list to be seen by the inhouse dental provider on their next scheduled visit in August 2025. She stated because the facility knew that Resident #21 was going to remain in the facility long term on his admission, the dental	F0791		

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F0791 SS = D	Continued from page 10 care options that were available to him in the facility should have been explained to his RP and either the consent or declination documented in Resident #21's medical record. The Administrator stated she thought she had spoken with Resident #21's RP at some point and she declined dental care for Resident #21.	F0791		
F0812 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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews the facility failed to discard out of date leftover resident food items stored in the facility's resident nourishment refrigerator. This deficient practice was for 1 of 1 resident nourishment refrigerators reviewed. Findings included: On 8/5/25 at 11:21 AM an observation of the facility's resident nourishment refrigerator with Dietary Manager #1 revealed a sign on the refrigerator door indicating it was the resident's refrigerator. Blank labels were observed in a plastic sleeve on the door with a sign reading, "All food requires a name and date. Food left	F0812	Corrective Action for the Resident Affected On 08/05/2025, the Dietary Manager removed the items from the nourishment refrigerator in the dining room that were not properly labeled, expired and or dated. Corrective Action for the Residents Potentially Affected The facility only has 1 nourishment refrigerator. Systemic Changes On, 08/05/2025, the Senior Nurse Consultant in-serviced the Administrator on monitoring the nourishment refrigerators, specifically checking them for proper labeling, dating and removing food items with signs of spoilage. On 08/05/2025, the Administrator in-serviced the Dietary Manager on monitoring the nourishment refrigerators, specifically checking them for proper labeling, dating and removing food items with signs of spoilage. On, 08/11/2025, the Dietary Manger in-serviced the dietary staff on monitoring the nourishment refrigerators, specifically checking them for proper labeling, dating and removing food items with signs of spoilage. Any staff member that was not available for the in-service will be taken off the schedule until they receive the in-service. All newly hired staff will receive the in-service during the orientation process. Quality Assurance The Administrator will monitor the nourishment refrigerator daily for 7 days, then 3 times a week, for 4 weeks, then monthly utilizing the QA Monitoring Tool for Food Procurement, Store/Prepare/Serve-Sanitary, to ensure that items are properly dated, stored and that no items are showing signs of spoilage. Any concerns to be addressed during the monitoring process. The results of these reviews to be submitted to the Quality Assurance & Performance Improvement (QAPI) Committee by the Administrator for review by the IDT	08/21/2025

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F0812 SS = E	Continued from page 11 past 2 days will be discarded". Dietary Manager #1 was interviewed during the observations. The interior of the refrigerator revealed one large white foam container labeled and dated 7/27/25 containing cooked chicken, one large white foam container labeled and dated 7/27/25 containing corn, macaroni and cheese, and cooked greens which all appeared hard and dry, and a plastic bag labeled and dated 7/26/25 containing an unrecognizable hard, light pink rectangular object that Dietary Manager #1 reported appeared to be turkey breast. Continued observations revealed a small square white foam container labeled and dated 8/1/25 containing a slice of blueberry pie topped with whipped cream, an unlabeled and undated square white foam container containing a portion of white cake with frosting, and a rectangular clear plastic container with a red lid labeled and dated 7/25/25 with unrecognizable contents that Dietary Manager #1 indicated were possibly beans. In an interview during the observation, Dietary Manager #1 reported all the items should have already been discarded as they were past the time limit of 3 days and the cake was unlabeled and undated. She reported it was her responsibility to check the resident's nourishment refrigerator daily Monday through Friday for unlabeled or past date items. She stated all food should be labeled with the resident's name and the date it was placed in the refrigerator and should be discarded after 3 days. She reported she had not checked the refrigerator yet today and had not checked it yesterday. She stated she had gotten busy in the kitchen yesterday and forgot. Dietary Manager #1 stated the last time she had checked the refrigerator would have been last week and she did recall some of those items had been in there at that time. On 8/7/25 at 8:32 AM an interview with the Administrator indicated it was Dietary Manager #1's responsibility to check the resident's nourishment refrigerator for out of date food items which should be discarded after 2 days in accordance with the facility's policy.	F0812	Continued from page 11 members monthly. Quality monitoring schedule modified based on findings. Date of Compliance: 08/21/2025	