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	345286	A. BUILDING _____ B. WING _____	C 10/12/2020

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on-site 10/5/2020 thru 10/7/2020 and off-site 10/7/2020 thru 10/12/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# SSL511.	E 000		
F 000	INITIAL COMMENTS An unannounced complaint and infection control survey was conducted onsite from 9/30/2020 - 10/1/2020 and 10/5 - 7/2020 and remotely 10/8 - 12/2020. Associated event ID 09CD12 Two of the 37 complaint allegations were substantiated resulting in deficiencies (F755 and F804).	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on hospital record review, facility record review, observation, resident, psychiatric nurse practitioner, physician, and staff interviews, the facility failed to provide supervision of direct care staff to prevent a physical altercation between 2 of 5 residents, Resident #2 and Resident #10,	F 689	1.Identified concerns for resident #10 were reviewed in Ad Hoc committee meeting on 10/20/2020. Ad Hoc Meeting included Administrator, Director of Nursing, Medical Director, and Chief Medical Director of Eventus. Ad Hoc	11/2/20

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

Electronically Signed | 10/27/2020

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F 689	Continued From page 1 that were reviewed for accidents. Resident #10 entered Resident #2 ' s room and a physical altercation between the two residents developed. Resident #10 struck Resident #2 with her hand on the left side of her face resulting Resident #2 being transported to the Emergency Room for evaluation and treatment. The facility ' s failure to provide supervision continued as Resident #10 was allowed to continue to wander throughout the facility, displaying periods of agitation, and wandered back into the room of Resident #2. The findings included: Resident #2 was admitted to the facility on 5/22/18 and her cumulative diagnoses included: Generalized weakness, anxiety, and lack of coordination. A review of Resident #2 ' s Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 8/24/20. The resident was coded as having been cognitively intact. For Activities of Daily Living (ADLs) the resident was coded as having required supervision or limited assistance with setup help or the support of one person for bed mobility, transfer (such as into and out of bed to a wheelchair), moving about the unit, dressing, toilet use, personal hygiene, and bathing. The resident was listed as having been independent for walking in her room, walking on her hall, moving about off the unit, and eating. The resident was coded for not having displayed any behaviors. Resident #2 ' s care plan, which had been most recently updated on 8/25/20, documented the resident had a focus area for the resident having	F 689	meeting consisted of a review of resident #10’s current medications and behaviors. Facility placed a Velcro stop sign on Resident #2 door to keep resident #10 from entering 2.On 10/22/2020 Ad Hoc committee along with Eventus Psych Services, Medical Director reviewed all residents with known behaviors to ensure care plans reflected behaviors that could result in similar issues. Care plans were also reviewed for residents with wandering, or exit seeking behaviors 3. The DON (director of nursing) or designee provided the licensed nursing staff with training related to accident/incidents investigation, notifying attending physician and nurse practitioner of any change of condition, safety & supervision of residents on 10/14/2020 and 10/15/2020. This information will be included in the new hire orientation and provided to the agency staff by the Staff Development Coordinator/ designee 4. Random audits will be performed on incident and/ or behavior reports by Director of Nursing, Social Services and/ or designee will be completed 5 times weekly for 1 month and then 5 times monthly for 2 months; any concern will be addressed immediately, and the results of the audits will be discussed during the monthly QAPI meeting.	

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been non-compliant with care per staff such as changing her oxygen settings on her oxygen concentrator throughout the day. Interventions for the focus area were: Intervene as necessary to protect the rights and safety of others, monitor behavior episodes, and attempt to determine underlying cause, including considering location, time of day, person involved, and situations.

Resident #10 was admitted to the facility on 9/29/17. The resident ' s cumulative diagnoses included: Dementia with behaviors.

A review of Resident #10 ' s Minimum Data Set (MDS) assessment revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 7/1/20. The resident was coded as having moderate cognitive impairment. For Activities of Daily Living (ADLs) the resident was coded as having required extensive assistance of 1-2 people for bed mobility, transfer (such is into and out of the bed to and from a wheelchair), dressing, toilet use, and personal hygiene. Walking in the corridor and moving about her unit was coded as having occurred 1-2 times with the assistance of one person during the assessment period. The resident was not coded for any behaviors during the assessment period.

Resident #10 ' s care plan, which had been most recently revised on 9/3/20, included the following focus area: Resident had an elopement risk/wanderer related to disoriented to place and impaired safety awareness secondary to Alzheimer ' s. Interventions listed were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversations, television, or a book. Additionally,

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the resident had an intervention documenting the resident triggered for wandering due to propelling around the building. Further review of the care plan identified the resident had a behavior problem of physical behaviors related to cognitive loss/dementia with behavioral disturbance. Interventions for physical behaviors focus area were to intervene as necessary to protect the rights and safety of others, approach the resident and speak to the resident in a calm manner, divert the resident ' s attention, removed the resident from the situation, and to take alternate action as needed. The resident also had an intervention to minimize potential for the resident ' s disruptive behaviors of hitting staff by offering tasks which divert attention. A focus area for the resident receiving antipsychotic medications related to dementia with behavioral disturbance had an intervention which listed to observe/record occurrence of for target behavior symptoms (specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others) and document per facility protocol. A focus area for the resident being at risk for visual decline related to glaucoma.

Review of Resident #10 ' s September Medication Administration Record (MAR) revealed the resident received the following medications as ordered from 9/1/20 through 9/29/20; Divalproex 125 milligrams (mg) delayed release capsule one time a day orally for mood/behaviors (start date of 2/6/20) and quetiapine fumarate 75 mg one time a day orally for behaviors. Behavior monitoring was documented as having been conducted daily but the specifics of the observed behavior was not documented in the MAR.

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An incident report dated 9/25/20 and timed 7:40 PM, which was completed by Nurse #1, was reviewed. The incident report detailed a family member from Resident #2 called the facility and stated Resident #2 had been hit in the face by another resident. Resident #10 was discovered in the room of Resident #2 and was immediately removed. Resident #10 stated Resident #2 had hit her once on the left side of her face in the cheek area after she had told Resident #10 to get out of her room. Resident #10 stated to the nurse she had hit Resident #2 after Resident #2 had hit her first. Further review revealed Resident #10 was placed on every 15 minute checks. There were no documented injuries to either resident.

During a phone interview conducted with Nurse #1 on 9/30/20 at 7:16 PM she stated on the evening of 9/25/20 at about 7:40 PM, she had received a phone call from a family member of Resident #2 informing her that Resident #2 had just been punched in the face by another resident. The nurse stated she went to Resident #2 ' s room, the call light was not on, and the door was closed. She said when she went into the room, she said Resident #10 was near the door to the hallway, inside the room, and Resident #2 was over by her bed and told the nurse the resident had hit her once in the face. She said she did not see any marks on Resident #2 or Resident #10. She then said Resident #10 left the room without incident and was placed on every 15 minute checks. The nurse said the family member of Resident #2 later called and requested for Resident #2 to be sent out to the Emergency Room (ER) due to complaints of dizziness and the resident was sent via Emergency Medical Services (EMS) at about

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9:15 PM. The nurse stated when she talked to Resident #10, she stated Resident #2 had hit her first, and then she hit her back but was unable to identify where she had been hit. The nurse explained due to the dementia of Resident #10 she was unable to get further information from the resident when she talked to her later. The nurse described Resident #2 as being capable from being in a good mood and then going to be in a bad mood, and can panic easily, be slightly aggressive, but had not seen her hit anyone. The nurse stated when she was receiving report on 9/29/20 she had heard that Resident #10 had gone back into Resident #2 ' s room, but was removed without incident, and the unit manager was trying to get a stop sign banner to go up in front of the door in an effort to try to keep Resident #10 from going back into Resident #2 ' s room.

Resident #2 was interviewed on 9/30/20 at 8:31 AM and then corroborated and clarified information during a second interview conducted at 2:18 PM. During the interview the resident stated another resident (Resident #10) had come in and punched her twice in the head, once on the left cheek and the other time on the side of her forehead. The resident stated when the resident had punched her, it had knocked the glasses off of her face. She said the resident came into her room and she told the resident to get out because it was not her room. She then continued and said the resident was in a wheelchair, and closed the room door behind her after she came in. She explained the resident was backed up against the door and when she tried to move the resident, she punched her in the face. She said it was at that time when she called her daughter. The resident stated she went out to the hospital after

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she was hit. The resident further stated the same resident had come back into her room two more times on 9/29/20. She said on one occasion the resident came into her room and started to mess with the blanket on her bed, she rang the call light, and a nurse came into the room and removed the resident. She said there was another occasion when the resident came to the door of the room and started to come in her room. She told the resident to leave and the resident turned around and left. The resident stated the other resident came into her room three times in total. The resident described the event when she was hit as terrible and was afraid the resident was going to return to her room.

Review of the progress notes for Resident #2 revealed a note from Nurse #1 dated 9/25/20 at 7:40 PM which documented a family member of Resident #2 called the facility and informed her Resident #2 had been hit in the face by another resident. Resident #10 was discovered in the room of Resident #2. Resident #2 was observed to have had no bleeding from her face. Resident #10 was removed from the room and placed on every 15 minute checks. Resident #2 stated Resident #10 had hit her once in the face to the left cheek area. A head to toe assessment by the nurse revealed no bruising, redness, or edema to the face of Resident #2. Resident #2 had no complaints of pain, she was alert and oriented, and neurological assessments were initiated. A family member of Resident #2 contacted the facility and informed the nurse Resident #2 was complaining of dizziness, had a raised area to her head, and was requesting for Resident #2 to be transported to the emergency room immediately. Emergency Medical Services (EMS) was contacted and the resident went out to the

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Emergency Room (ER) via EMS.

Review of a hospital emergency room report from 9/25/20 through the night to 9/26/20 for Resident #2 revealed a physical exam by the ER physician documenting the resident had a 1 centimeter (cm) in diameter reddened bruise to the left temple. The ER physician documented the resident was complaining of pain in the left temple and the area to the left of the left eye. The physician further documented the resident had complaints of dizziness and headaches.

Review of the progress notes for Resident #10 revealed a note by Nurse #1 from 9/26/20 at 7:56 PM documenting Resident #10 had allegedly hit Resident #2 in the face.

A progress note of Resident #2 dated 9/26/20 and timed 10:39 AM by Nurse #2 documented the resident returned from the hospital and the resident had complaints of her left cheek hurting from being slapped.

A phone interview was conducted on 10/1/20 at 1:36 PM with the Unit Manager (UM). The UM stated she had removed Resident #10 from the room of Resident #2 on 9/29/20. She stated sometimes when Resident #10 was pulled back, while in her wheelchair, she can become agitated, but she was not agitated on 9/29/20. The UM further stated Resident #10 was checked on every 15 minutes for the first 24 hours, then checked every hour after that. The resident was checked on to see where she was and that she was OK. The UM also stated she remembered hearing in the shift report that Resident #2 had hit Resident #10 and then Resident #10 hit Resident #2 back. She also stated Resident #10 was nice

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most of the time, but then would have periods where she would be agitated, non-compliant with care, and her periods of agitation usually happen in the afternoon.

During an interview with Nurse #2 conducted on 9/30/20 at 10:20 AM she stated Resident #10 had dementia, was pleasantly confused, but could get combative, agitated, and if someone were to do something to her when she was agitated, she would hit them. She explained the resident had occurrences when she had hit staff members who were trying to provide care. The nurse stated she had not seen the resident get agitated with another resident to the point she had hit another resident and she had seen the resident wander into other residents ' rooms.

Nursing Assistant (NA) #1 stated during an interview conducted on 9/30/20 at 10:29 AM she had experiences with Resident #10 when she had been combative when she was attempting to provide care. The NA stated the resident was confused and thinks she ' s working at the facility. The NA explained the resident would go around in her wheelchair, would tell people what to do, and would go into other residents ' rooms. The NA also stated the resident would hit someone who tried to move her chair, but she had not seen her hit another resident.

An interview was conducted on 9/30/20 at 1:30 PM with the physician for Resident #2. The physician stated he had seen the resident on 9/28/20 and the resident told him her face was still sore from when another resident had come into her room on 9/25/20 and had hit her on the left cheek and the left forehead. The physician stated the resident had told him she had not done

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anything to agitate the resident who had come into her room. The physician further stated he was aware the resident had been sent out to the ER on 9/25/20 due to the resident ' s complaints of having been dizzy but a computerized tomography (CT) scan revealed no major injury (i.e. subdural hematoma). The physician stated they had been adjusting medications for Resident #10 and stated he believed she was at a good level presently.

A phone interview was conducted with the Psychiatric Nurse Practitioner (PNP) on 9/30/20 at 2:19 PM. She stated they had been adjusting medications for Resident #10. She explained she was not pleased to hear about Resident #10 having hit Resident #2. The PNP stated she had last seen Resident #10 on 9/11/20 and at that visit the resident appeared to have been stable. She stated she had not been informed Resident #10 had gone back into Resident #2 ' s room and stated the resident needed to be monitored due to her behaviors. The PNP stated her plan was to conduct a video appointment with the resident on 10/1/20 and she would determine what, if any action, needed to be taken at that time.

A direct observation of Resident #10 conducted on 9/30/20 at 3:24PM revealed the resident to have been in her wheelchair and traveling on the 300 hall (the resident resides on the 600 hall) away from her room and toward the 100/200 halls.

A direct observation of Resident #10 conducted on 9/30/20 at 3:33 PM revealed the resident to have been in her wheelchair and at 100 hall/200 hall nurses station (the resident resides on the 600 hall).

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An interview was conducted on 9/30/20 at 3:37 PM with NA #2 and he stated Resident #10 had been on his assignment on 9/25/20 and 9/29/20. He stated they had been trying to keep Resident #10 near the nurses ' station because of the incident between her and Resident #2, and that she had wandered into other residents ' rooms.

An observation of Resident #10 conducted on 9/30/20 at 3:58 PM revealed the resident to have been in her wheelchair and at the Assisted Living Facility (ALF) doorway and repeatedly stating she wanted to go through the doors. The resident was not easily redirected by staff members when they were attempting to redirect the resident to another part of the building. The resident continued to argue with staff members and kept trying to turn her chair towards and propel to the ALF doors.

An interview was conducted on 9/30/20 at 4:10 PM with the Staff Development Coordinator (SDC). The SDC stated after the observation of Resident #10 at 3:58 PM the resident stated to get away from her and called her a "b**ch." The resident then continued and stated, "I ' m going through those damn doors." The SDC stated that was when they got the Medication Technician (MT) from the ALF hall to come help. She said that was the first time she had seen the resident behave like that.

During an interview with the MT conducted on 9/30/20 at 4:15 PM she stated Resident #10 had come through the doors to the ALF unit and when she had tried to redirect the resident, the resident responded, No, I ' m going out there through those double doors to go home. The MT stated

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the resident was determined to go through the doors to go home. The MT said the resident told them she was going to kick them, and the resident tried to swing and hit them. The MT further stated it was the first time she had seen Resident #10 go through the ALF doors.

A continuous observation of Resident #10 conducted on 9/30/20 from 4:24 through to 4:44 PM revealed the resident to be behind the nurses ' station and was backing her wheelchair up repeatedly and banging into a wooden paper shred box. The resident was visibly agitated and would back into the paper shred box with her wheelchair and the resident ' s right hand were observed to be clenched around the wheelchair handrim pulling back on the right wheel which resulted in the wheel pushing against the paper shred box. A staff member was observed trying to assist the resident with her facemask and the resident took a swing with her right fist at the staff member. The resident was talking in a low tone and was not talking to anyone specifically and seemed to be rambling in a manner which she could not be understood. When the UM sat down at the nurses ' station the resident called the nurse a "big ass woman." The resident was observed to attempt to swing and hit two more staff members who attempted to assist the resident with her facemask. The resident would intermittently attempt to back up and bang off the paper shred box. The resident eventually placed the facemask on by herself.

A second phone interview was conducted the PNP on 10/1/20 at 3:30 PM. The PNP stated resident #10 was drastically different during her video appointment with the resident today than she was back on 9/11/20. She stated the

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resident had told her to "go to hell" during the appointment and told the facility social worker (SW), You ' re aggravating me, leave me alone. The PNP also stated the resident was asking for her mother and wanted to get out of the house. The PNP stated she wanted to make sure there was not a different medical condition which would have been causing the resident ' s behavior and the resident ' s physician had some blood labs drawn. The PNP stated she reviewed the labs and did not feel there was anything clinically wrong with the resident, such as an infection because the labs were stable. The PNP stated she was quite surprised with the resident ' s mood and was surprised the resident was even agitated and aggressive with the SW which was something she had never seen before. The PNP explained due to not being able to identify a suspected medical condition which her behavior could be attributed to she was going to propose a change in the resident ' s psychotropic medications to see if that would help with her behaviors and draw more labs in a week to be sure there were no medical conditions which may still arise which the behaviors could be attributed to.

A phone interview was conducted on 10/2/20 at 1:55 PM with the Director of Nursing. She stated Resident #10 was placed on 15 minute checks for a little while, then hourly checks went on for 3 days and she should not be on hourly checks right now because it was only for 3 days, but she did not know if there were sign off sheets for the resident being monitored. The DON checked the progress notes for Resident #10, and it said the hourly checks were continued and said maybe there were three more days of hourly checks because Resident #10 went into Resident #2 ' s

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room. The DON then stated Resident #10 was trying to go into Resident #2 ' s room on 10/1/20 and she was redirected. The DON stated she had received reports from staff that Resident #10 had become more agitated but had not had any altercations on 10/1/20 or 10/2/20. The DON further stated the resident had not had any further episodes of behavior like what the resident displayed on 9/30/20 at the nurses ' station in the afternoon. The DON then went to the nurses ' station and discovered the resident was still on hourly checks and they were documented in the resident ' s hard chart.

During an interview with the administrator conducted on 10/2/20 at 2:22 PM she stated she had been informed Resident #2 had experienced no injuries as a result of the physical altercation with Resident #10. She also stated she had not been made aware Resident #10 had gone back into the room of Resident #2. The administrator stated Resident #10 had a history of wandering, but was easily redirectable, and no one had reported to her she had been displaying increased behaviors. She said she was aware Resident #10 had been trying to go down the ALF hall, but as she stated, the resident just needed to be redirected, but sometimes with redirection, she would come back again. The administrator also stated they have been able to divert the resident in the past through food. The administrator stated she had received the updated from the PNP which she was going to recommend changing the resident ' s psychotropic medications due to unmanageable behaviors and physical aggression towards another resident. The administrator stated she felt like the monitoring which was put into place was an appropriate first step.

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F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, dietician interview, staff interview, Nurse Practitioner interview and observations, the facility failed to act upon dietician recommendations to increase liquid protein from twice per day to four times per day for 1 of 3 residents reviewed for nutrition (Resident #9). Findings included: Resident #9 was admitted to the facility 5/3/2019 and readmitted 4/29/2020 with diagnoses to include respiratory failure, dementia, protein-calorie malnutrition and adult failure to	F 692	Corrective Actions that will be accomplished for those residents found to have been affected by the deficient practice: 1. Identified concerns were corrected during the survey. Care plan meeting was held with the resident #9 to discuss care plans on 10/28/20 along with Responsible Party via telephone. Medications were discussed. 2. The policy and procedure relative to dietary recommendation, notification of MD/NP of recommendations were reviewed on 10/15/2020 by the Director of	11/2/20

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F 692	Continued From page 15 thrive. Resident #9 had a physician order dated 5/6/2020 for a regular diet, pureed texture. An order dated 5/7/2020 for Resident #9 ordered liquid protein 30 milliliters (ml) twice per day for wound healing. The most recent quarterly Minimum Data Set (MDS) assessment dated 7/20/2020 assessed Resident #9 to be severely cognitively impaired. He required total assistance with eating, difficulty swallowing and received a mechanically altered diet. The MDS assessed Resident #9 to have 3 pressure ulcer wounds. The MDS documented weight loss for Resident #9 and the weight was recorded as 100 pounds. A care plan dated 7/15/2020 addressed Resident #9 ' s nutritional needs related to wounds and significant weight loss. Interventions were modified by the dietician on 5/14/2020 noting Resident #9 had multiple wounds and significant weight loss. The dietician modified the care plan on 8/12/2020 to provide liquid protein 30 ml twice per day. According to the medical record, Resident #9 ' s weight was 104.1 pounds on 8/4/2020. A dietician note dated 9/2/2020 documented 18% weight loss after hospitalization in April 2020. The note documented Resident #9 had a left buttocks wound that was improving, and a sacral wound that was deteriorating. The note documented the development of a blister on the left heel. The dietician calculated nutritional needs for Resident #9 and estimated he required 1400 calories per day with 94 grams of protein per day. The dietician noted Resident #9 ate 50-100% of his	F 692	Nursing 2. The DON (director of nursing) or designee provided the licensed nursing staff with training related to above-mentioned policies and procedures on 10/15/20 and 10/16/20.This information will be included in the new hire orientation and provided to the agency staff by the Staff Development Coordinator/ designee 3. On 10/14/2020, an Ad-Hoc Quality Assurance Process Improvement committee (QAPI) meeting was held to discuss the alleged deficiencies and Plan Of Correction. Ad Hoc committee included the Administrator, Director of Nursing, Nursing Administration, Social Services, Culinary Services Manager, and two R&R Management consultants Clinical meetings will be held Monday through Friday to discuss resident change of condition ensure compliance. Weekend Supervisor/ designee will review Incident reports and Change of Conditions and report to the Director of Nursing for further recommendation 3. All Dietary recommendation will be tracked and audited to ensure compliance for a period of three (3) months by the Director of Nursing/ designee. The result of the audit will be documented in the monitoring tool titled, Consultant Recommendation Audit. 4. Random Audits will be completed by the Director of Nursing/ designee 5 times weekly for 4 weeks and then 5 times monthly for 2 months beginning on 11/2/20 The results of the audits will be	

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F 692	Continued From page 16 meals and was receiving supplementation in the form of the liquid protein twice per day, house shakes with breakfast, fortified juice with lunch, ice cream with supper, and Ensure plus at bedtime and based on that intake he was eating 1400-1500 calories per day and getting 60 grams of protein. The dietician recommended to increase the liquid protein to four times per day to provide Resident #9 with 60 grams of protein per day (30-gram increase from prior order). The dietician recommended to discontinue the fortified juice, fortified ice cream and staff to encourage protein-containing food items to increase protein intake for wound healing. The dietician estimated with the removal of the supplements, increase in liquid protein, Resident #9 would receive adequate calories and 95 grams of protein per day. The dietician nutritional recommendation dated 9/2/2020 documented Resident #9 had significant weight loss and wounds and she recommended increasing liquid protein from twice per day to four times per day, after meals and at bedtime to support weight maintenance and increase protein for wound healing. The dietician also recommended discontinuing the fortified juice and the fortified ice cream. Based on review of the physician orders from 9/2/2020 through Oct 6, 2020, there were no physician orders to increase the liquid protein to four times per day. There were no physician orders to discontinue the fortified juice or the fortified ice cream. A phone interview was conducted with the Registered Dietician (RD) on 10/7/2020 at 8:58 AM about the nutritional recommendation of	F 692	discussed during the monthly QAPI meeting. 5. The Facility□s Administrator or designee (DON) shall monitor all staff identified in this POC to ensure that staff are functioning in accordance with this POC and the State and Federal requirements. Dates when corrective action will be completed.	

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9/2/2020. The RD reported Resident #9 had multiple issues, including pressure ulcers that were deteriorating and weight loss. Resident #9 had variable meal intakes that required supplementation. The RD reported she adjusted Resident #9 ' s caloric and protein needs based on his current weight and the number of pressure wounds. The RD reported she emailed the list of nutritional and supplemental recommendations on 9/2/2020 to the Director of Nursing (DON), the Administrator, the Dietary Manager and to the corporate office officials for review and then to be given to the facility physician or nurse practitioner (NP) for signing. The RD reported she had received acknowledgement the email was received by the recipients. The RD reported she was not aware the liquid protein had not been increased for Resident #9 per her recommendations.

The DON was interviewed on 10/7/2020 at 9:32 AM and she reported the unit manager was responsible for putting the RD recommendations into the physician or NP box for approval.

The Unit Manager (UM) was interviewed on 10/7/2020 at 11:12 AM. The UM reported she had not seen the RD recommendations for September 2020 for Resident #9. The UM was interviewed again on 10/8/2020 at 8:21 AM by phone. The UM reported that she started her position on 9/14/2020 and had not been responsible for the RD recommendations.

The NP was interviewed on 10/9/2020 at 1:57 PM. The NP reported that she or the physician would review RD recommendations and write orders if they agreed with the recommendations. The NP reported she had not received the

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September 2020 RD recommendations for Resident #9. The NP reported based on Resident #9 ' s comorbidities, the additional protein may have improved wound healing.

According to the medical record, Resident #9 ' s weight was 98.6 pounds on 9/23/2020.

Review of Resident #9 ' s food intake from 9/14/2020 through 9/30/2020 revealed no refusals of meals, 7 meals documented as consumed 0-25%, 21 meals consumed 26-50%, 18 meals consumed 51-75% and 12 meals consumed 76-100%.

Resident #9 was observed on 10/7/2020 at 2:00 PM. He was non-verbal and unable to answer questions. Resident #9 ' s lunch tray was observed on 10/7/2020 at 1:55 PM. He had eaten 100% of the pureed food and had drank approximately 2 ounces of the fortified juice.

Nursing assistant #3 was interviewed on 10/7/2020 at 1:55 PM and she reported Resident #9 ate well for her, but he would not drink all the fortified juice and he often held the juice in his mouth and refused to swallow it.

A review of the medication administration record for September 2020 revealed Resident #9 had received liquid protein 30 ml twice per day as ordered.

A phone interview was conducted with the Administrator on 10/12/2020 at 1:04 PM. The Administrator reported during the last part of August and first part of September 2020 there were some management changes. The Administrator reported that the RD

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F 692	Continued From page 19 recommendations were emailed to the DON and the DON was responsible for communicating the nutritional recommendations to the physician or NP. The Administrator reported she was not certain why the RD recommendations were not given to the physician or NP for review.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		11/2/20

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F 755	Continued From page 20 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff, physician, resident interviews, pharmacy and nurse practitioner interviews, the facility failed to acquire and administer heart medication for a resident with atrial fibrillation for 1 of 5 residents (Resident #4) reviewed for medication administration. The findings included: Resident #4 was admitted to the facility on 9/19/15 with diagnoses of atrial fibrillation. On 2/19/20 a physician's order for Resident #4 was written for Propafenone capsule 325 milligrams by mouth two times a day for atrial fibrillation. Resident #4's Medication Administration Record (MAR) for September 2020 indicated doses of Propafenone 325 milligrams were scheduled to be given at 9:00 AM and 9:00 PM. The MAR had a documented code of "9" for 9/6/20, for the 9:00 AM dose, 9/21/20 for the 9:00 AM and 9:00 PM doses and the 9/22/20 9:00 PM dose. The MAR chart codes revealed "9" indicated "other/see nurse notes". A nurse's note dated 9/6/20 at 11:07 AM read "Pharmacy bringing tonight awaiting all back from NP to hold until come. Resident has no adverse reactions noted. Will continue to monitor and assist this shift". A nurse's note dated 9/21/20 at 8:24 AM read "Propafenone HCL on order". A nurse's note dated 9/21/20 at 8:39 PM read	F 755	Corrective Actions that will be accomplished for those residents found to have been affected by the deficient practice: 1. Identified concerns were corrected during the survey. Care plan meeting was held with the resident #4 to discuss care plans on10/19/20 along with Responsible Party. 2. The facility completed an initial facility-wide audit of all medications and medication orders. The initial audit was completed on 10/16/2020 by the Nursing Administration team 2. The policy and procedure relative to medication availability, medication administration, medication ordering and preventing medication errors were reviewed on 10/14/2020 by the Director of Nursing 3. The DON (director of nursing) or designee provided the licensed nursing staff with training related to above-mentioned policies and procedures beginning on 10/14/2020. The Staff Development Coordinator will educate new hires during orientation and agency staff prior to beginning on the floor. 3.On 10/14/2020, an Ad-Hoc Quality Assurance Process Improvement committee (QAPI) meeting was held to discuss the alleged deficiencies and Plan Of Correction. Ad Hoc committee included the Administrator, Director of Nursing,	

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F 755	Continued From page 21 "med not available, waiting for pharm to deliver". A nurse's note dated 9/22/20 at 11:32 PM read "waiting for medication from pharmacy". On 10/6/20 at 8:21 AM during a medication administration observation. Nurse #1 stated Resident #4's Propafenone medication was not available and was ordered from the pharmacy that morning. She stated the medication aide told her the medication was out that morning. On 10/6/20 at 8:25 AM, Medication Aide #1 was interviewed. She stated she administered Resident #4's medications that morning and she was out of Propafenone. There was no card. She stated when there are 8 pills left on the card, they are supposed to reorder. The MAR has a button that they click to reorder medications. She stated she was off since Thursday, so she didn't know if it was reordered or not. The medication aide also stated she tells the nurse when a medication is out, and she follows up with pharmacy. If a medication is out on the morning medication pass and the nurse calls the pharmacy, it will usually be sent by 4 pm that day. On 10/6/20 at 9:45 AM, Resident #4 was interviewed. She stated she had not received her Propafenone yet today because the medication was out. Resident #4 added the facility ran out of the medication back in September also. On 10/6/20 at 9:48 AM, an interview was conducted with the Pharmacy Technician. She stated she just received a telephone call from someone at the facility stating Resident #4 was out of Propafenone. She added the medication cards have a blue area that indicated when to reorder. Reordering was done on the electronic	F 755	Nursing Administration, Social Services, Culinary Services Manager, and two R&R Management consultants 4. Random audits will be completed by the Director of Nursing/ designee 5 times weekly for 3 months; any concern will be addressed immediately, beginning 11/2/20. The results of the audits will be discussed during the monthly Quality Assurance Process Improvement committee meeting.	

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MAR by pushing the reorder button. She stated if the medication orders are put in correctly, the pharmacy sends the medication on receipt of the reorder. She noted the medication was reordered on 9/5/20 and was sent to the facility on 9/6/20, but not in time for the 9:00 AM dose. She added the pharmacy sent a 14-day supply of Propafenone on 9/6/20 and on 9/21/20 the facility called the pharmacy requesting a refill which was sent on 9/22/20 at 12:30 AM.

On 10/6/20 at 2:39 PM, the Medical Director was interviewed. He stated he did not provide care to Resident #4 and her provider should be notified first when medications are not given. He added he was made aware that morning that Resident #4's Propafenone was not administered.

On 10/7/20 at 12:50 Pm, an Interview with the Nurse Practitioner revealed she was aware of the problem with medications not being ordered timely. She stated she was not informed of the missing dose of medication yesterday on 10/6/20. She stated she would expect to be informed about that. She added the resident's medication is for arrythmia and is intended to keep her in rhythm so a missing dose or more could cause adverse consequences.

On 10/12/20 at 9:20 AM, an interview was attempted but unsuccessful with Med Aide 1, who was the medication aide responsible for medication administration for Resident #4 on 9/21/20 at 9:00 AM.

On 10/12/20 at 9:25 AM, an interview was attempted but unsuccessful with Nurse #1, who was the nurse responsible for medication administration for Resident #4 on 9/21/20 at 9:00

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F 755	Continued From page 23 PM. On 10/12/20 at 11:14 AM, an interview was conducted with the Pharmacy Consultant. He stated he was unaware Resident #4 was running out of her medication. He added checking the MAR for missed doses was not part of his monthly medication review. On 10/12/20 at 1:04 PM, an interview was conducted with the Administrator. She stated she understood there was a glitch in the medication ordering process. When the facility staff put orders into the order system, the orders weren't always flowing to the pharmacy. She added she expected resident orders to be placed correctly and nursing staff call to the pharmacy to check that orders were received.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interview, staff interviews, Pharmacy, Nurse Practitioner and Physician interviews, the facility failed to prevent significant medication errors for 1 of 5 residents (Resident #4) reviewed for medications errors. Resident #4 did not receive doses of an extended release heart medication, used to treat irregular heart rhythm. The findings included: Resident #4 was admitted to the facility on 9/9/15	F 760	Corrective Actions that will be accomplished for those residents found to have been affected by the deficient practice: 1. Identified concerns were corrected during the survey. Care plan meeting was held on 10/19/20 with the affected resident and Responsible Party to discuss care plans and medications 1. The policy and procedure relative to	11/2/20

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F 760	Continued From page 24 with a diagnosis of atrial fibrillation. A quarterly Minimum Data Set assessment dated 8/14/20 revealed Resident #4 was cognitively intact. Record review revealed a physician's order, which originated on 2/19/20, for Propafenone capsule 325 milligrams by mouth two times a day for atrial fibrillation. (Propafenone is a medication used to treat irregular heart rhythm). A review of Resident #4's Medication Administration Record (MAR) revealed doses of Propafenone extended release 325 milligrams were scheduled to be administered at 9:00 AM and 9:00 PM. The Propafenone was documented as not given on 9/6/20 for the 9:00 AM dose and 9/21/20 for the 9:00 AM and the 9:00 PM doses. Regarding the 9:00 AM missed Propafenone dose on 9/6/20, a nurse documented on 9/6/20 at 11:07 AM, "Pharmacy bringing tonight awaiting call back from NP to hold until come. Resident has no adverse reactions noted. Will continue to monitor and assist this shift". Regarding the 9:00 AM missed Propafenone dose on 9/21/20, a nurse documented on 9/21/20 at 8:24 AM, "Propafenone HCL on order". On 10/12/20 at 9:20 AM, an interview was attempted but unsuccessful with Med Aide #1, who was the medication aide responsible for medication administration for Resident #4 on 9/21/20 at 9:00 AM. Regarding the 9:00 PM missed Propafenone dose on 9/21/20, a nurse documented on 9/21/20	F 760	medication availability, medication administration, medication ordering and preventing medication errors were reviewed on 10/14/2020 by the Director of Nursing 3.. The DON (director of nursing) or designee provided the licensed nursing staff with training related to above-mentioned policies and procedures beginning on 10/14/2020 and 10/15/2020. The Staff Development Coordinator will educate new hires during orientation and agency staff prior to beginning on the floor. 4. On 10/14/2020, an Ad-Hoc Quality Assurance Process Improvement committee (QAPI) meeting was held to discuss the alleged deficiencies and Plan Of Correction. Ad Hoc committee included the Administrator, Director of Nursing, Nursing Administration, Social Services, Culinary Services Manager, and two R&R Management consultants 4. Random audits will be completed 5 times weekly by the Director of Nursing/ designee for 3 months beginning on 11/2/2020; any concern will be addressed immediately, and the results of the audits will be discussed during the monthly QAPI meeting. 5. The Facility□s Administrator, Director of Nursing or designee shall monitor all staff identified in this POC to ensure that staff are functioning in accordance with this POC and the State and Federal requirements.	

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F 760	Continued From page 25	F 760		

at 8:39 PM, "med not available, waiting for pharm to deliver".

On 10/12/20 at 9:25 AM, an interview was attempted but unsuccessful with Nurse #1, who was the nurse responsible for medication administration for Resident #4 on 9/21/20 at 9:00 PM.

On 10/6/20 at 8:21 AM during a medication administration observation. Nurse #2 stated Resident #4's Propafenone medication was not available and was ordered from the pharmacy that morning. She stated the medication aide told her the medication was out that morning.

On 10/6/20 at 8:25 AM, Medication Aide #1 was interviewed. She stated she administered Resident #4's medications that morning and she was out of Propafenone, so could not be administered.

On 10/6/20 at 9:45 AM, Resident #4 was interviewed. She stated she had not received her Propafenone yet today because the medication was out. Resident #4 added the facility ran out of the medication back in September also.

On 10/6/20 at 2:39 PM, the Medical Director was interviewed. He stated he did not provide care to Resident #4 and her provider should be notified first when medications are not given. He added he was made aware that morning that Resident #4's Propafenone was not administered that morning.

On 10/7/20 at 12:50 Pm, an Interview with the Nurse Practitioner revealed she was aware of the problem with medications not being ordered

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F 760	Continued From page 26 timely. She stated she was not informed of the missing dose of medication yesterday on 10/6/20. She stated she would expect to be informed about that. She added the resident's medication is for arrythmia and is intended to keep her in rhythm so a missing dose or more could cause adverse consequences. On 10/12/20 at 1:04 PM, an interview was conducted with the Administrator. She stated she expected medications to be administered as ordered.	F 760		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and monitoring of foods on a requested test tray the facility failed to serve hot foods at an appetizing temperature for 2 of 2 residents reviewed for food palatability (Residents #2 and #11). Findings included: 1a. Resident #2 was readmitted to the facility on 2/28/2020 with diagnoses to include lung disease and diabetes. The most recent quarterly	F 804	Corrective Actions that will be accomplished for those residents found to have been affected by the deficient practice: 1. Re-education of Culinary Services Manager (CSM) on Next Level policies & Procedures regarding Nutritive Value, Appearance & Palatability and Re-education of Culinary Staff on Next Level policies & Procedures regarding Nutritive Value, Appearance & Palatability was completed on 10/15/2020 by the	11/2/20

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F 804	Continued From page 27 Minimum Data Set assessment dated 8/24/2020 assessed Resident #2 to be cognitively intact. Resident #2 was interviewed on 10/6/2020 at 11:11 AM. The resident reported that at most meals the food she received was cold when served. Resident #2 did not have specific examples of cold food, but reported it happened frequently. Resident #2 reported she occasionally asked for her food to be reheated. Resident #2 was interviewed on 10/6/2020 at 2:00 PM. Resident #2 reported the temperature of the food she received on her lunch meal tray, which included chicken and dumplings and carrot, were cold "that was normal." The resident stated she would prefer for her hot foods to be served hot at meals. b. Resident #11 was readmitted to the facility on 2/7/2020 with diagnoses to include lung disease and hypertension. The most recent quarterly Minimum Data Set assessment dated 8/6/2020 assessed Resident #11 to be cognitively intact. An interview was conducted with Resident #11 on 10/6/2020 at 11:15 AM. The resident reported the food she received at meals was usually cold. Resident #11 reported she received cold food several days per week and at all meals. Resident #11 reported she would request to have food reheated. Resident #11 was interviewed on 10/6/2020 at 2:04 PM. Resident #11 reported the noon meal was good, but the food she was served, including chicken and dumplings and carrots, were cold when she received her meal tray. The resident stated she would prefer for her hot foods to be served hot at meals.	F 804	Regional Director of Culinary Services. 2. Any resident can be affected by the alleged deficiency. The measures the facility will take or systems the facility will alter to ensure the problem will be corrected and will not recur: 1. Food Committee to occur Bi-Monthly, Hosted by activities director □ attended by Culinary Services Manager, minutes to be recorded on Food Committee form. 2. Review of policies and procedures related to Next Level regarding Nutritive Value, Appearance & Palatability was completed and re-education of Culinary Services Manager (CSM) and Culinary Staff on was completed on 10/15/2020 by the Regional Director of Culinary Services 1. Culinary Department completed an initial customer service audit of alert & oriented residents (evidenced by BIMS) started on 10/15/2020 to determine area of focus (meal/location) and will continue customer service audits for a minimum of five (5) weekly x 12 weeks and report findings to the Quality Assurance Process Improvement committee for review and recommendation. All results will be discussed during food committee meetings. 2.Test Tray Audits to be completed five (5) times weekly x 12 weeks by the Culinary Services Manager beginning on 11/2/2020 This will occur in the repeating order of Breakfast on Monday & Thursday, Lunch on Tuesday & Friday, Dinner on Wednesdays. All results will be reported &	

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F 804	Continued From page 28 A test tray was requested during the noon meal of 10/06/20. The test tray was prepared in the kitchen and left the kitchen at 1:17 PM to be delivered to the floor. The foods served on the test tray were tasted with the Regional Dietary Manager (RDM) at 1:32 PM. The chicken and dumplings were served in a plastic bowl. No steam was evident upon removing the plastic lid from the bowl. The chicken and dumplings were cool to the touch and taste. The carrots were served on a covered plate. When the plate cover was removed no steam was noted to rise from the carrots and the carrots were cool to the touch and taste. The RDM was interviewed on 10/6/2020 at 1:32 PM. The RDM agreed that the temperature of the chicken and dumplings and carrots that were served on the test tray were not warm. The RDM reported she had decided to serve the chicken and dumplings in a plastic bowl because it appeared more appetizing in the bowl, as opposed to served on the heated plate. The RDM reported that the plates were heated, and each plate had a heated pellet (a metal disk used under the plate keep food warm) and an insulated top to keep the food warm until it was served. The Corporate Dietary Manager (CDM) was interviewed on 10/7/2020 at 10:03 AM. The CDM reported that the pellets and plate were still hot when the food was served, and she was not certain why the food was cooling down so quickly. The Administrator was interviewed by phone on 10/12/2020 at 1:04 PM. The Administrator reported it was her expectation the residents received food at the appropriate temperature.	F 804	discussed in Interdisciplinary Team stand up & stand down as deemed appropriate. 5. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance. 6. The Facility□s Administrator or designee shall monitor all staff identified in this POC to ensure that staff are functioning in accordance with this POC and the State and Federal requirements. Dates when corrective action will be completed.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to sanitize food preparation pots and pans that were washed in the kitchen ' s 3 compartment sink and failed ensure stored food preparation pans were clean and dry. Additionally, foods in kitchen freezer storage were not closed and were not dated and pork loin roasts in the cooler were not stored covered. This had the potential to affect 88 out of 92 residents. Findings included: 1. An observation, with the Dietary Manager (DM), was made on 10/05/20 at 9:10 AM of food preparation pans that were stored on a kitchen shelf and were ready for use. Six food	F 812	Corrective Actions that will be accomplished for those residents found to have been affected by the deficient practice: 1. Re-education of Culinary Services Manager (CSM) on Next Level Policies & Procedures for Sanitation & Storage by the Regional Director of Culinary Services was completed on 10/15/2020 2. Re-education of Culinary Staff on Next Level Policies & Procedures for Sanitation & Storage was completed on 10/15/2020by the Regional Director of Culinary Services 2.. Review of Next Level policies and	11/2/20

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F 812	Continued From page 30 preparation pans were stacked together and had moisture on them. Two additional stored food preparation pans were stored unclean with a dried food residue on them. Observations on 10/5/20 at 9:41 AM of the kitchen ' s the 3-compartment sink revealed the sink ' s third compartment (the sanitizing tank) was filled with food preparation pots and pans and water. Cook #1 was observed to use a test strip to check the quaternary ammonia (a chemical used to disinfect handwashed dishes) level of the water in the sink ' s third compartment. The test revealed there was no quaternary ammonia in the sink ' s water to sanitize the pots and pans that were being washed by Cook #1. Cook #1 reported she had not put any quaternary ammonia in the sink because she did not know that it was required. When Cook #1 was asked why the sink ' s third compartment was filled with pots and pans that were soaking in the water, she replied, "that is how I do it." On 10/5/20 at 9:50 AM the Dietary Manager (DM) checked the quaternary ammonia dispenser and found that it was empty. The DM then informed Cook #1 that the quaternary dispenser needed to be replaced. Observations on 10/6/20 at 9:25 AM of the kitchen ' s 3 compartment sink with the Regional Dietary Manager (RDM) revealed the quaternary ammonia dispenser was still empty. Cook #1 was asked to replace the empty quaternary dispenser and fill up the sink ' s third compartment with water and enough quaternary ammonia disinfectant. Cook #1 reported she had not received training on how to fill the sink or replace	F 812	procedures related to Sanitation & Storage was completed on 10/15/2020 by the Regional Director of Culinary Services. 2. Re-education of Culinary Services Manager (CSM) and Culinary Staff on above-mentioned policies was completed on 10/15/2020 by the Regional Director of Culinary Services 1. Sanitation audits will be completed by Next Level regional staff or the facility administrator one (1) time a week x 12 weeks on weekly sanitation audit form beginning on 11/2/2020. Findings will be reported to the QAPI committee for review and recommendation. The administrator will present results of the audits to the quality assurance committee x 3 months. The Quality Assurance Process Improvement committee may modify this plan to ensure the facility remains in compliance 2. Nutrition Plus representative will complete an unannounced sanitation audit one (1) time a week for 2 months and then monthly X 1 month and report findings to the QAPI committee for review and recommendation beginning on 11/2/2020. The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance 3. The CSM will complete the manager checklist twice daily five (5) times a week x 12 weeks and report findings to the QAPI committee for review and recommendation beginning on 11/2/2020.	

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F 812	Continued From page 31 the quaternary ammonia in the dispenser. Cook #1 reported she had been washing the dishes in the kitchen ' s 3-compartment sink the way she thought they should be washed. On 10/6/2020 at 9:30 AM the RDM demonstrated filling the third compartment of the 3 compartment sink with water and quaternary sanitizer. The RDM filled the sink with water, added quaternary sanitizer to the water and then used a test strip to check the level of the quaternary ammonia in the water, which was 200 parts per million (ppm). The RDM confirmed a concentration of 200 ppm or more of quaternary ammonia in the sink ' s water was sufficient to sanitize items being washed in the kitchen ' s 3 compartment sink. Observations on 10/6/20 at 9:55 AM reveled the RDM separated two food preparation pans that were stacked together on a shelf and stored ready for use. When separated both of the stored food preparation pans were observed to have moisture on them. The RDM was unable to explain why the pans were stacked together and stored wet. An interview was conducted with the RDM and the Corporate Dietary Manager (CDM) on 10/7/2020 at 10:03 AM. The CDM reported the kitchen ' s orientation processes had not been followed and dietary staff were not trained on the equipment and sanitizer use. The CDM was unable to explain why stored food preparation pans were wet and not clean. The Administrator was interviewed on 10/12/20 at 1:04 PM. The Administrator reported the former DM had not provided oversight or training to the kitchen staff and the RDM was providing	F 812	The administrator will present results of the audits to the quality assurance committee x 3 months. The QAPI committee may modify this plan to ensure the facility remains in compliance. 4. The Facility□s Administrator, or designee shall monitor all staff identified in this POC to ensure that staff are functioning in accordance with this POC and the State and Federal requirements.	

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F 812	Continued From page 32	F 812		

in-services and training to all staff on the correct use of the kitchen ' s 3-compartment sink. The Administrator reported it was her expectation the kitchen followed regulatory guidelines for dish sanitizing.

2. a. Observations on 10/05/20 at 9:35 AM of the kitchen ' s walk-in freezer, with the dietary manager (DM) revealed; a package of okra, a package of french fries and a package of chicken cutlets were stored in the walk-in freezer and each of these foods were stored open to air and not dated.

b. Observation on 10/05/20 at 9:30 AM of the kitchen ' s walk-in refrigerator, with the DM revealed two pork loin roasts that were only partially covered with parchment paper were stored in the refrigerator. The DM reported the pork roasts were cooling and the facility planned to serve them "tomorrow."

An observation on 10/06/20 at 10:00 AM revealed the two pork loins remained stored in the walk-in refrigerator and were still only partially covered with parchment paper. The Regional Dietary Manager (RDM) reported, at this time, the pork roasts were not going to be served and would be discarded.

An interview was conducted with the RDM and the Corporate Dietary Manager (CDM) on 10/7/20 at 10:03 AM. The CDM reported the kitchen ' s orientation processes had not been followed. The CDM was unable to explain why foods stored in the kitchen ' walk-in cooler and freezer were open to air and not dated.

The Administrator was interviewed on 10/12/2020

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F 812	Continued From page 33 at 1:04 PM. The Administrator reported the former DM had not provided oversight or training to the kitchen staff and the RDM was providing in-services and training to all staff regarding the storage of food and not storing foods opened. The Administrator reported it was her expectation the kitchen followed regulatory guidelines for food safety.	F 812		