STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The survey team entered the facility on 4/19/21 to conduct a Recertification survey. The survey team was onsite 4/19/21 through 4/22/21. Additional information was obtained offsite 4/23/21 through 4/27/21. Therefore, the exit date was 4/27/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# GBRD11	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 4/19/21 to conduct a recertification survey, focused infection control survey and complaint investigation. The survey team was onsite 4/19/21 through 4/22/21. Additional information was obtained offsite 4/23/21 through 4/27/21. Therefore, the exit date was 4/27/21. 11 of the 30 complaint allegations were substantiated. 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# GBRD11 During the IDR process the state survey agency deleted an example from F550 June 1, 2021.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		5/19/21

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

Electronically Signed | 05/19/2021

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F 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide a dignified dining experience by talking on a cell phone while aiding with feeding for 1 of 8 residents (Resident #114) reviewed for dining. This was evidence of 1 of 8 residents reviewed for dignity. Findings included:	F 550	1.Resident#114 did not recieve the full interaction expected from a staff member assisting him with his meal.The resident was interviewed by the social work department on 4-21-2021 and had no concerns and did not wish to file a grievance.The cna was counceled by our	

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F 550	Continued From page 2 Resident #114 was admitted to the facility on 11-7-19 with multiple diagnosis that included encephalopathy, dysphagia, contracture of muscle right hand, contracture of muscle left hand and severe protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) dated 4-7-21 revealed Resident #114 was minimally cognitively impaired and was coded for needing extensive assistance with one person for eating. Resident #114's care plan dated 4-8-21 revealed a goal that he would improve his current level of function. The intervention for the stated goal was in part; the resident requires extensive assistance from staff to eat. Resident #114 was observed on 4-21-21 at 9:15am. The resident was observed sitting up in bed assisted by a nursing assistant (NA #1) to eat his breakfast. NA #1 was observed sitting on the edge of the resident's bed talking on her cell phone while she was assisting Resident #114 to eat his breakfast. The NA was observed to end her call when Resident #114 raised his hand to say hello. During an interview with NA #1 on 4-21-21 at 9:20am, the NA acknowledged she should not have been on her cell phone. The NA also said she did not look for a chair because she stated, "I always sit on the bed with him." The Administrator was interviewed by telephone on 4-26-21 at 9:26am. The Administrator discussed NA #1 was employed by an agency and that agency staff were not vested in the residents. She also stated she expected staff to	F 550	Director of nursing in a one on one education on 4-21-21. The Director of nursing did an insevice with the nursing staff reguarding patient engagement,infection control and also re educated the staff and referenced the companys cell phone policy on 4-22-21. 2. No other residents were affected. 3.The facility will observe and or interview the residens to ensure satisfaction with the meal service assistance. customer service audits wil be done 2 x per week x 4 weeks,then weekly x 4 weeks by the don or designee. 5.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. completion Date is 5-19-2021	

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F 550	Continued From page 3 engage the residents they are assisting during mealtimes and not talk on their cell phones.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to ensure 1 of 35 Residents (Resident #118) reviewed for call light accessibility, was able to reach their call light. Resident #118 was unable to reach for his call light due to left side weakness and contracture of the left hand. Findings included: Resident #118 admitted to the facility on 5/6/2020 with diagnoses of stoke with left side weakness and contractures to left upper extremity. An Annual Minimum Data Set (MDS) Assessment dated 4/6/2021 for Resident #118 revealed he was cognitively intact and had decreased range of motion to both upper extremities. The assessment further revealed Resident #118 required extensive assistance of two staff members for turning in the bed. Resident #118's Care Plan dated 4/8/2021 stated his call light should be in reach and he should be encouraged to call for assistance as needed.	F 558	I. Facility failed to ensure accommodation of needs for Resident who required the call bell to be secured to the oppisite side of the bed . Resident # 118 call bell was attached to the right side of his bed on 4-19-2021 by the Director of Nursing.The residents care plan was updated and this information was also added to the cnas daily electronic information for charting. No other residents affected. 2. A facility observation round was conducted on 04/19/2021 by the Director of nursing, Therapy Director, and Assistant Director of Nursing (ADON) and Unit Managers. The observation included ensuring residents have the call bell with in reach and are able to operate the call bell,no other residents affected. 3.Beginning 5/17/21, the DON or designee will conduct facility observations daily x 5 days a week x 4 weeks,then weekly for (4) weeks to ensure	5/19/21

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F 558	Continued From page 4 On 4/19/2021 at 11:45 am an observation and interview was conducted with Resident #118. Resident #118's call light was wrapped around his left side rail and he was not able to use his left hand to touch his call light. Resident #118 was not able to turn himself with his right hand to reach the call light. Resident #118 stated often on the 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am shifts the Nurse Aides will tie his call light to the side rail on the left side of his bed. He stated he cannot move his left hand or arm. Resident #118 stated he waited for the Nurse Aides to come into his room to ask for what he needs and when the 7:00 am to 3:00 pm Nurse Aides come in he asks them to move his call light to the right side. Resident #118 stated he had asked the 3:00 pm to 11:00 pm and 11:00 pm to 7:00 pm staff to move his call light to his right side so many times he finally gave up and did not ask anymore. Resident #118 stated Nurse Aide #4 clips the call light to the right side of his shirt so he can reach it. An interview with Nurse #2 was conducted 4/21/2021 at 10:45 am she stated she had not been told Resident #118's call light was tied to his left side rail, out of his reach. During an interview with Nurse Aide #4 on 4/21/2021 at 10:58 am she stated Resident #118 told her the 3:00 pm to 11:00 pm and 11:00 pm to 7:00 am shift Nurse Aides tie his call light to the siderail on the left side of his bed Nurse Aide #1 stated she does find the call light tied to the left side rail frequently and she moves the call light to Resident #118's right side and clips it to his shirt so he is able to use it.	F 558	accommodation of needs for residents who may have difficulty reaching their call bell to ensure it is located in the best possible position for that individual. 4. We will continue facility observations for a minimum of three (3) months, the Directors will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. 5. The Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed. Completion date 5-19-21.	

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F 558	Continued From page 5 An interview was conducted with the Administrator on 4/22/2021 at 12:53 pm and she stated the staff needed to be educated regarding Resident #118's call light placement on his left side since he could not move that arm or hand. The Administrator stated she had not been made aware Resident #118 had complained about his call light being out of his reach.	F 558		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		5/19/21

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F 561	Continued From page 6	F 561		

facility.
This REQUIREMENT is not met as evidenced by:
Based on record review, observation, and resident and staff interviews the facility failed to provide showers for 1 of 35 residents (Resident #19) when their choice was to have a shower at least two times a week.

Findings included:

Resident #19 admitted to the facility on 7/25/2018 with diagnoses of stroke with weakness and kidney failure which required dialysis.

A Quarterly Minimum Data Set (MDS) Assessment dated 2/1/2021 revealed Resident #19 was cognitively intact; required extensive assistance with personal hygiene and total assistance of bathing; and did not have behaviors.

Resident #19's electronic documentation of bathing for 3/2021 revealed Resident #19 did not have a shower but received bed baths and partial bed baths.

The electronic documentation of bathing for 4/2021 was reviewed and Resident #19 was not documented as having a shower and received bed baths and partial bed baths.

An interview was conducted 4/19/2021 at 12:41 pm with Resident #19 and he stated he had not had a shower in a long time. He stated he did not know when he should get a shower, but he would like to have one at least two times a week. A review of the posted shower schedule that was not dated and was found at the Nurses' Station

1. Facility failed to provide choices specifically showers as scheduled for Resident#19.Resident #19 was showered on 4-19-21 and continues to recieve showers when he request and s scheduled.
No other residents affected.

2. Education was provided from 05-17-2021 to nursing staff by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) related to ensuring care choices and activities of daily living (ADL) care is provided with emphasis on ensuring bathing is completed as scheduled and/or requested.

3. nursing staff will be educated by Director of nursing and or designee to ensuring care choices and activities of daily living (ADL) care is provided.

4.Beginning 5/17/21, ADL audits/bathing audits will be conducted by the DON, ADON and/or Unit Manager (UM) twice weekly for (4) weeks ,then monthly x 3 months to ensure bathing is completed as scheduled.

Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further

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F 561	Continued From page 7 indicated Resident #19 should receive a shower on Tuesdays and Fridays. An interview with Nurse Aide #5 on 4/22/2021 at 9:32 am revealed she tried to give Resident #19 a shower every other week, but she did not have enough time to get everyone showered. Nurse Aide #5 stated her assignment was very hard and she did the best she could. Nurse Aide #5 stated Resident #19 never refused a shower and she gives him a bed bath if she does not have time to give him a shower. Nurse Aide #6, who works as a Medication Aide, was interviewed on 4/22/2021 at 9:35 am and she stated Resident #19 should get a shower every Tuesday and Friday. Nurse Aide #6 stated she had never known Resident #19 to refuse a shower. An interview was conducted with Nurse #3 and she stated Resident #19 refused showers because he wanted to smoke . During an interview with the Director of Nursing on 4/22/2021 at 12:20 pm she stated she was not aware Resident #19 was not getting his showers. The Director of Nursing stated Resident #19 should be getting showers twice a week and whenever he wanted a shower. An interview was conducted with the Administrator on 4/22/2021 at 12:46 pm and she stated staff should follow the facilities shower schedule and give residents a shower whenever they request.	F 561	auditing beyond the three months. 5. Director of Nursing will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		5/19/21

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F 584	Continued From page 8	F 584		

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

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F 584	Continued From page 9 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, family, and staff interview the facility failed to provide a homelike environment for Resident #76 whose personal belongings were misplaced after several room changes during the COVID pandemic. This was evidence for 1 of 3 residents reviewed for personal property. Finding Included: Resident #76 was admitted to the facility on 08/01/19. The annual Minimum Data Set (MDS) dated 03/24/21 indicated that Resident #76 had a Brief Interview Mental Status (BIM) score of 15; was able to make his needs known to staff and had no behaviors noted. Resident #76 required extensive assistance to total dependence on staff for all his activities of daily living. Resident #76's care plan dated 03/26/21 he had accepted this placement as his home and would remain at the facility for long-term care. Goal indicated the facility would continue to help him meet his needs daily. Interventions included the facility would remind Resident #76's family members and friends they may bring items from home to help Resident #76 adjust to living in the facility as his home. A complaint/grievance report done on 11/13/20 revealed Resident #76 was missing some of his personal items. The grievance report indicated some of his clothes were missing from his	F 584	1.Resident #76 was moved to the covid unit after testing positive for covid,after his stay on the covid unit he was moved to the observation unit.The resident was then moved back to his origional room. The resident reported missing items and he did a grievance.The residents items that were stored and were returned to his room when he moved back in. The facility will make every reasonable effort to minimize loss or damage to residents personel possessions and shall make provisions for safe keeping personal items as requested. The facility social work director is in process of contacting the school archives department to see if a copy of the photos can be obtained,if possible the facility will obtain a copy and return them to the resident. We will continue to investigate and determine the cause of any such disapperance,loss or damage.The resident was provided a secure lock box,and if requested,locked cabniets and drawers in accordiance to our sighned admission agreements. 2. No other residents were effected. 3.The facility will move the residents items if a complete room change is indicated,and the resident is not expected to return to their previous room.All items will be packed up in a box or tote to	

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F 584	Continued From page 10 wardrobe and the facility replaced these and labeled them. The facility would continue to place the residents clothing back in his room when laundry got them and cleaned and dried. No information was known on the missing pictures. During an interview with Resident #76 on 04/19/21 at 11:30am he indicated he got the COVID-19 virus in months of June and July of 2020 and had to be transferred to the COVID unit. Resident #76 indicated his personal clothes and personal items did not go with him. There were several pictures stolen and/or missing. The pictures were of his graduation from 1969 and his wife from 1971. Resident #76 indicated the pictures had not been found and he did not understand why someone would take the pictures. He stated he wanted his pictures back. The resident explained his family called and talked with the Social Worker about the pictures and as of today (04/19/21) the pictures had not been returned. During an interview with the Administrator on 04/20/21 at 2:30pm, she indicated the facility replaced Resident #76's missing clothing and she personally hung the resident's clothes back up in January 2021. The Administrator also indicated she observed some pictures in a box in his room however she was unsure who was in the pictures. She added she would investigate this. A family member (FM) interview was conducted on 04/21/21 at 9:00am, she indicated that she contacted the facility back in November 2020 and called again in January 2021 concerning the missing pictures and Resident #76 missing clothes. FM spoke with the Social Worker at the Facility. The FM indicated that the facility had not	F 584	protect breakables and labeled with the room number and the owners name.The housekeeping staff will place the items in storage and keep a record of where each residents boxes are located inside the building.The facility re-educated nusing staff and housekeeping staff on 5-18-2021 as to the new procedure for the moving and storage of residents items. 4.The daily visual observation and completion of a tracking record for residents items will be completed by the Director of enviiormental services when it is nessessary for a resident to move out of their origional room.The items and the logs will be visualized 2 x a week while the items are being stored. 5.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Completion date 5-19-2021.	

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F 584	Continued From page 11	F 584		

contacted her about this information yet. The FM indicated that the pictures were very sentiment to us. (to the resident)

During a second interview with Resident #76 on 04/21/21 at 3:15pm he stated some of his clothes were never replaced and no one had talked to him about his missing pictures.

During an interview with Social Worker (SW) on 04/22/21 at 8:30am, SW indicated she remembered talking to Resident #76's family member about the missing pictures. The SW indicated the facility looked in Resident #76's room and in the boxes of his personal items but the pictures could not be found. She indicated that she would reach out to the family again. The SW also indicated the Housekeeping staff had transported Resident #76's personal belonging downstairs and she was unsure what happened to the pictures.

During an interview with Housekeeping Manager (HM) on 04/22/21 at 3:00pm he indicated the Nursing Assistants were the ones that packed up residents clothing when they were moved from their room to the COVID unit. The HM indicated the only time housekeeping staff would do this was when they unpacked the residents clothing to be wash by the laundry department. The HM staff indicated he never observed any pictures in Resident #76 boxes.

During an Interview with Nursing Assistant (NA) #42 was completed via phone on 04/23/21 at 5:00pm. NA #42 indicated she was not the NA who packed Resident #76's personal items. She was working on the COVID-19 unit from March 2020 to January 2021 and she did not recall

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F 584	Continued From page 12 packing up Resident #76's personal items. NA #42 also indicated there were still plenty of boxes downstairs and she would look in the boxes for Resident #76's pictures. NA #42 indicated that she had observed Resident #76 pictures in his room before Resident #76 was moved. During an interview with the Administrator on 04/23/21 at 2:00pm she indicated Resident #76 had changed room several times due to the virus and moved to several rooms in general. The Administrator stated she did not recall Resident #76's pictures. She also indicated that she was informed by the SW the family had called about the pictures. The Administrator added she had not seen the pictures during her last contact with Resident #76. She stated she wasn't sure why any resident would have a picture with so much value in their room. Her expectation was the facility would replace items the facility had misplaced for all residents if there was proof of what the resident reported missing.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the swallowing and nutrition section (Section K) on the Minimum Data Set (MDS) assessment for 2 of 15 residents (Resident #134) reviewed for MDS accuracy. Findings included:	F 641	1.corrective action will be accomplished for Both residents #134 and #129 whose weights were verified by The Nursing Department. Dietary orders verified by the director of nursing. The mds assesments for resident # 129 was modified and resubmitted on 4-28-21.resident #134 was discharged to	5/19/21

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F 641	Continued From page 13 1.Resident #134 was admitted to the facility on 4-9-20 with multiple diagnosis that included diabetes and secondary malignant neoplasm of the left lung. Review of the physician order dated 11-18-20 revealed Resident #134 was to receive a regular textured diet. Review of Resident #134's physician orders from February 2021 through April 2021 revealed no orders for the resident to receive tube feeding or water through his feeding tube. The annual Minimum Data Set (MDS) dated 4-8-21 revealed Resident #134 was cognitively intact and coded for receiving water and tube feeding through his feeding tube. During an interview with Nurse #1 on 4-22-21 at 1:45pm, the nurse stated Resident #134 did not receive tube feeding or water through his feeding tube. The dietary manager was interviewed on 4-22-21 at 2:55pm. The dietary manager stated she had made a mistake. She explained she should have marked zero because the resident had not received any feeding or water through the feeding tube. The Administrator was interviewed by telephone on 4-26-21 at 9:26am. The Administrator stated she expected the dietary manager to follow state and federal guidelines. She explained she did not know why the dietary manager had coded Resident #134 for receiving tube feeding and water through his feeding tube.	F 641	the hospital and was transitioned to hospice. The weights to follow will be verified for accuracy by the director of nursing and entered in the documentation for our electronic documentation system,weight loss identified will be screened for assistance with meals at our clinical meetings. 2. The registered dietician audited all tube feeding residents and orders to ensure accuracy for flushes, tube feeding product and amounts, also to identify any resident that was previously a tube fed resident who has converted to po but still has the gtube in place on 5-7-2021. 3. The facility will identify other residents having the potential to be affected by the same practice by auditing section k of the residents most recent mds to be completed by 5-18-21. The MDS Coordinators will make any needed Modifications to section K and verify the the ARD date to ensure accuracy of the mds, with follow up from the Director of nursing. 4.MDS staff, were re-educated by the Regional MDS consultant on 05/7/2021 regarding the importance of accurately coding section k of the MDS, updating the care plans and entering the task instructions in the task section for the cnas. 5.Data obtained during the audit process	

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F 641	Continued From page 14 2. Resident #129 admitted to the facility on 5/6/2019 with diagnoses of heart failure and schizophrenia. An Annual Minimum Data Set (MDS) Assessment dated 4/7/2021 revealed Resident #129 required extensive assistance with eating and had significant weight gain. Review of the medical record revealed Resident #129 weight was 93.7 pounds on 4/7/2021; 134.6 pounds on 3/14/2021 (30% weight loss in one month); and 119.2 pounds on 11/17/2020 (21% weight loss in six months). On 4/22/2021 at 12:24 pm an interview was conducted with the Administrator. The Administrator stated the MDS Nurse would be responsible for any assessments that were coded incorrectly. She stated Resident #129 had lost a lot of weight and she was being monitored for weight loss. During an interview with the MDS Nurse on 4/22/2021 at 1:31 pm she stated the Dietary Manager would have coded if Resident #129 had weight loss or weight gain on the 4/7/2021 Annual Minimum Data Set (MDS) Assessment. The MDS Nurse stated the date was changed on the Annual Minimum Data Set (MDS) Assessment from 4/4/2021 to 4/7/2021 and she had signed the sections off for the Dietary Manager when she changed the date. During an interview with the Dietary Manager on 4/22/2021 at 1:37 pm she stated there had been an inconsistency in the resident's weights and the facility had a plan of correction in place to ensure weights were correct. She stated she used a	F 641	will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months.At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Completion date is 5-19-2021	

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F 641	Continued From page 15 weight that was obtained on 4/4/2021 for the 4/7/2021 assessment. (No weight was recorded for 4/4/2021 in the medical record). She stated she did not know how the resident was coded as significant weight gain if she was a significant weight loss. An interview was conducted 4/23/2021 at 4:55 pm with the Administrator. The Administrator stated she felt the discrepancy in the weight section of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date(ARD) of 4/7/2021 for Resident #129 was caused by the change in the Assessment Reference Date (ARD) of the assessment. The Administrator stated the staff should code the Minimum Data Set (MDS) Assessments with the correct information.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		5/19/21

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F 656	Continued From page 16 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to follow care plan interventions for a resident with a history of falls for 1 of 2 residents reviewed for accidents (Resident #21). Resident #21 had a history of fall with injury. Findings included: Resident #21 was admitted to the facility on 04/12/16 with diagnoses that included history of fractures, cerebral infarction, type 2 diabetes mellitus, muscle weakness, repeated falls,	F 656	1. The facility failed to follow a care plan interventions for a resident # 21 who was identified as a fall risk.The resident did not sustain a fall on 4-21-21,or 4-22-21.The fall mats were replaced on 4-22-21,his residents care plan was reviewed and new interventions were put in place per interdisiplinary team. 2.No other reesidents were affected. 3.A care plan audit will be performed by the MDS Coordinator(s) to ensure that all care plan interventions are in place. This	

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F 656	Continued From page 17 unsteadiness of feet, atrial fibrillation, osteoporosis, hypertension, and congested heart failure. The Minimum Data Set (MDS) quarterly assessment dated 02/01/21 revealed Resident #21 had moderate cognitive impairment and demonstrated no moods or behaviors. He required extensive assistance with 1 staff physical assistance with bed mobility and did not transfer during the assessment period. Further review of the MDS revealed resident was not steady and only able to stabilize with staff assistance with moving from seated to standing position, and from surface to surface transfers. Additionally, the MDS revealed Resident #21 had a fall with major injury since admission or prior assessment. A care plan reviewed on 02/02/21 revealed a plan of care for risk for further falls with fracture related to gait/balance problems, incontinence, psychoactive drug use, history of fall with right hip fracture, osteoporosis, and visual deficit. The interventions included, in part, floor mats on both sides of the bed. An observation was made on 04/21/21 at 9:06 am. Resident #21 was observed lying in bed. No floor mats observed on the floor next to the bed. Another observation was made on 04/21/21 at 12:55 pm. Observation of Resident #21 lying in bed with eyes closed. No floor mats observed An interview was conducted on 04/22/21 at 12:55 pm with NA #5. She stated she had cared for resident since her employment began in January	F 656	audit will be completed by 5-17-21. 4.Re-education of the development and updates on care plans was provided by facility MDS Consultant 5-7-21 to MDS Coordinator(s) and Interdisciplinary(IDT)Team.Education was provided to nursing Staff to utilize care areas identified on the care area summary. 5.careplans will be audited by 5-17-21 and on going for intervention updates. Audits will be conducted weekly x 4 weekly, monthly x 3 months. Progress will be reported to the QAPI committee by the Administrator.The administrator will be responsible for overall compliance. Data results will be reviewed and analyzed at the centers monthly QAPI meeting with a subsequent POC as needed completion date of 5-19-2021.	

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F 656	Continued From page 18 of 2021. She stated Resident # 21 had falls that usually occurred on other shifts. She stated he had not had a fall on her shift. NA #5 stated she had not seen any floor mats in Resident #21's room. An interview was conducted on 04/22/21 at 1:11 pm with Nurse #2. She stated she had worked in the facility for about a month and she was aware Resident #21 had a fall in April 2021. She indicated she was not aware of fall mats as an intervention for Resident #21. She entered Resident #21s' room to look for the floor mats, however, was unable to locate fall mats. She stated she would ask about them. On 04/22/21 at 2:08 pm and interview was conducted with MDS Nurse #2. He stated during the morning meetings the management team go over the falls and put interventions in place on the plan of care. He stated the Unit Managers would put the interventions in place after the meeting. He indicated the interventions on the plan of care were to be in place. On 04/22/21 at 2:20 pm an interview was conducted with Nurse #3 and she stated she became the Unit Manager on the Unit where Resident #21 resided in April 2021. She indicated it there had not been a consistent Unit Manager on Unit 300 and that maybe why the floor mats were not in place. An interview was conducted on 04/23/21 at 3:40 pm with the Administrator. She indicated interventions were to be followed according to the plan of care.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		5/19/21

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F 677	Continued From page 19 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and resident interview, the facility failed to provide a dependent resident with assistance in eating for 2 of 6 residents (Resident #114 and Resident #129) reviewed for activities of daily living. Findings included: 1.Resident #114 was admitted to the facility on 11-7-19 with multiple diagnosis that included dysphagia, contracture of muscle right hand, contracture of muscle left hand and severe protein-calorie malnutrition. Physician order dated 3-14-21 was reviewed and revealed an order that stated, "staff patient is a feeder/red tray status for all 3 meals." Review of Resident #114's weight on 4-6-21 revealed the resident weighed 121.5 pounds. The quarterly Minimum Data Set (MDS) dated 4-7-21 revealed Resident #114 was minimally cognitively impaired and was coded for needing extensive assistance with one person for eating. The MDS also had Resident #114 coded for weight loss. Resident #114's care plan dated 4-8-21 revealed a goal that he would improve his current level of	F 677	1.corrective action will be accomplished for those residents found to have been affected by the deficient practice. Both residents #114 and #129 weight were verified by The Nursing Department. The residents will be placed on the weekly weight list. The weights to follow will be verified for accuracy in the documentation in our electronic documentation system to ensure anyone with a weight loss will be screened for assistance with meals weekly at our clinical meeting,both residents #114 and #129 are being assisted with meals by staff. The registered dietician and dietary manager and nursing audited all residents□ diets and tray cards for accuracy completed on 5-14-21. All weights were audited to identify any weight loss and in accuracys in the documentation and orders to ensure the correct diets, supplements and also reviewed all residents with red tray statuses on 5-14-21. 3. The facility will identify other residents having the potential to be affected by the same deficient practice; The facility has put into place a 100 percent audit of all current residents that are identified as	

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F 677	Continued From page 20 function. The intervention for the stated goal was in part; the resident requires extensive assistance from staff to eat. Review of Resident #114's weight on 4-19-21 revealed the resident weighed 119.6 pounds. During an interview with the Dietary Manager on 4-19-21 at 10:30am, the Dietary Manager explained the red trays located on the tray line were for residents who needed assistance with eating. Resident #114 was observed on 4-19-21 at 1:15pm attempting to feed himself. The resident was observed to be holding a spoon wedged between his thumb and index finger. Resident #114 was able to scoop his food onto the spoon but was unable to get the spoon to his mouth before the food fell off the spoon. There were no staff members observed in the resident's room. Resident #114 was observed to have a red tray. An interview with Resident #114 occurred on 4-19-21 at 1:16pm. The resident was unable to speak in full sentences but was able to understand questions and answered by nodding yes or no. Resident #114 nodded yes when questioned if he needed assistance with eating. Observation of Resident #114's tray occurred on 4-19-21 at 1:30pm. The observation revealed the resident ate approximately 25%. Resident #114 nodded "no" when asked if a staff member had come in to assist him and nodded "no" when asked if he wanted a staff member to come and assist him. Resident #114 was observed on 4-20-21 at	F 677	needing assistance with meals done by nursing and rehab department completed on 5-18-21. The residents identified will have a physicians order put in place and be added to the dietary departments tray card system, added to the care plan as needing assistance and will also be added to the Certified nursing assistants electronic tasks so everyone will have the same information on each resident s status. 4.The Director of nursing and other administrative nurses will monitor mealtime to ensure the residents that need assistance are assisted, and the documentation is completed daily for meal intake percentages and completion of task by cna. The daily visual observation and task completion will be audited by the Director of nursing and or administrative nurses 5 x a week x 4 weeks, then once weekly x 4 weeks, then monthly until compliance is achieved. 5.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 677	Continued From page 21	F 677	completion date 5-19-2021	

9:05am sitting up in bed. The resident was observed attempting to remove the lids from the cups that were on his red breakfast tray. Resident #114 was unable to remove the lids.

A nursing assistant (NA #2) was interviewed on 4-20-21 at 9:07am. NA #2 explained it was her 3rd day working at the facility and she was unaware Resident #114 required assistance with his tray. She also explained she had not been educated that a red tray symbolized a resident required assistance.

NA #2 was observed on 4-20-21 at 9:09am to enter Resident #114's room and removed the lids off the cups but then exited the room without assisting the resident in eating.

Observation of Resident #114's breakfast tray, which was placed in the meal cart occurred on 4-20-21 at 9:30am. The observation revealed Resident #114 ate approximately 20% of his meal.

Resident #114 was interviewed on 4-20-21 at 9:32am. The resident nodded "no" when asked if a staff member had assisted him in eating his breakfast.

Observation of Resident #114's breakfast tray on 4-22-21 at 10:00am revealed the resident had not consumed any of his meal.

Resident #114 was interviewed on 4-22-21 at 10:01am. The resident nodded "no" when he was asked if a staff member had assisted him in eating his breakfast. Resident #114 also nodded "no" when questioned if he was hungry.

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F 677	Continued From page 22	F 677		

The nursing assistant (NA #3) was interviewed on 4-22-21 at 10:05am. NA #3 acknowledged that staff did not feed the resident but stated staff would look in the room to make sure he was ok. She also said Resident #114 did not like what he had for breakfast, so he did not eat. NA #3 stated she had not offered an alternative. She acknowledged the resident did not have anything to eat for breakfast.

An interview with the facility's Medical Director occurred on 4-22-21 at 2:00pm. The Medical Director discussed Resident #114's comorbidities and stated he could not correlate the resident not being fed by staff to the resident's weight loss. The Medical Director acknowledged he had written an order for Resident #114 to be fed by staff and that he expected his orders to be followed.

During a phone interview with the Administrator on 4-26-21 at 9:26am, the Administrator discussed the facility had a break in communication and that the order for Resident #114 was not transcribed onto the nursing assistant's kiosk.

2. Resident #129 was admitted to the facility on 5/6/2019 with diagnoses of heart failure and osteoarthritis.

An Annual Minimum Data Set (MDS) Assessment dated 4/7 /2021 revealed Resident #129 was moderately cognitively impaired; and required extensive assistance with eating. The Care Area Assessments (CAAs) for the Annual Minimum Data Assessment stated Resident #129 should receive a puree therapeutic diet with double

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	345092	A. BUILDING _____ B. WING _____	C 04/27/2021

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THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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portions on a red tray. The CAA also stated Resident #129 was independent with meals but needed assistance at times.

A Plan of Care, located on the electronic charting for nursing staff, which was not dated specified Resident #129 required assistance with feeding.

A Dietician's Progress Note date 4/11/2021 at 7:40 pm specified Resident #129 had required some assistance with meals and had ate 50-100% of meals.

During an interview on 4/19/2021 at 12:16 pm with Resident #129 stated she feeds herself most of the time but sometimes the staff will assist her. Resident #129 stated she had lost weight and she weighed less than 94 pounds.
Review of Resident #129's tray ticket for 4/19/2021 at the lunch meal revealed she should receive a pureed meal with low concentrated sweets and double portions.

An observation was conducted 4/19/2021 at 12:57 pm of Resident #129's lunch tray being delivered. Nurse Aide #7 brought Resident #129's lunch tray in the room, opened the ice cream, milk and juice and left the room, without providing assistance with the meal. Resident #129 attempted to open the butter from her tray for several minutes and then dropped it on the floor. Resident #129 had attempted to feed herself and had food on her hands. She yelled out for assistance and no one heard her. A request was made for Nurse Aide #7 to return to Resident #129's room and she stated she thought Resident #129 could feed herself and was not aware she needed assistance. Nurse Aide #7 stated residents that required with feeding receive

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their food on a red tray and Resident #129 did not have a red tray. She stated she did not know of any other way to know if a resident required assistance with their meal. Nurse Aide #7 assisted Resident #129 with her meal when she returned to the room and Resident #129 was able to eat.

During an interview with Nurse Aide #4 and observation of Resident #129 on 4/21/2021 at 9:33 am Nurse Aide #4 was feeding Resident #129 a snack cake and broke the snack cake into small pieces and handed them to her. When Resident #129 finished the snack cake, Nurse Aide #4 gave her a plastic drink cup with cheese puffs in it and left the room. Resident #129 attempted to take a cheese puff out of the cup. Resident #129 tried several times to remove the cheese puff and then dropped the cup in her lap and spilled the cheese puffs in her lap. After 10 minutes of observing Resident #129 try to pick a cheese puff up from her lap, a request was made for Nurse Aide #4 to come back to the room to assist Resident #129 with her cheese puffs. Nurse Aide #4 returned to the room and assisted Resident #129 with the cheese puffs. Nurse Aide #4 stated she would let the Nurse know Resident #129 needed assistance with eating.

An interview was conducted with Nurse #2 on 4/21/2021 at 10:13 am and she stated the Nurse Aides let the Nurse know if someone needs assistance with meals and the Nurse sends a referral to Speech Therapy to let them know a resident needs to be screened. Nurse #2 stated the Nurse Aides have a Plan of Care on the electronic charting that tells them if a resident needs assistance with meals. A copy of Resident #129's Plan of Care from the electronic charting

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F 677	Continued From page 25 revealed Resident #129 required assistance with meals. During an interview with the Director of Nursing on 4/22/2021 at 12:05 pm she stated residents that require assistance with meals receive their meals on a red tray and should be assisted with meals. The Director of Nursing stated Resident #129 required extensive assistance with her meals but she would sometimes get upset with staff if they tried to feed her meals. The Director of Nursing stated she had observed Resident #129 eat a snack without assistance without any issues. On 4/22/2021 at 12:34 pm an interview was conducted with the Administrator and she stated Resident #129 had a significant amount of weight loss and they were monitoring her weight loss. The Administrator also stated Resident #129 could feed herself and they wanted her to be as independent as possible.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		5/19/21

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F 688	Continued From page 26 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to apply a splint as recommended by therapy for 1 of 4 residents (Resident #118) reviewed for range of motion. Findings included: Resident #118 was admitted to the facility on 5/6/2020 with diagnoses of stroke with left side weakness and contractures to both hands and arms, and a contracture to the left knee. An Occupational Therapy Discharge Summary dated 7/27/2020 stated Resident #188 had left side weakness due to a stroke and contracture of the left hand. The Occupational Therapy Discharge Summary further stated Resident #188's discharge goal was to wear a left hand splint for 8 hours a day with no signs of redness, swelling, or skin breakdown to decreased further contracture to his left hand. An Annual Minimum Data Set (MDS) assessment dated 4/6/2021 revealed Resident #118 was cognitively intact and had decreased range of motion to the upper and lower extremities bilaterally. During an interview and observation of Resident #118 on 4/19/2021 at 11:45 am he stated he could not use his left hand or arm at all. Resident #118 was in bed with the head of his bed raised.	F 688	1. Resident # 118 had his splint applied on 4-22-21 by the Director of Nursing and was already recieving therapy services through 5-10-2021 for physical therapy,them occupational therapy 5-10-2021.This resident will be included in the daily audits for splinting applications. All other residents have the potential to be affected. The facility will identify other residents having the potential to be affected by the same deficient practice; The facility has put into place a 100 percent audit of all current residents by therapy department to identify any resident with a decrease in range of motion. The rehab department completed new screens with 100 percent of all residents on 5-10-2021. 2.The residents identified will be added to the therapy departments case load, there will be a physicians order for splints or any rehab services,then added to the nursing departments administration record, the residents care plan and Mds will also add to the residents task schedule for instructions for the cna to apply and to remove as ordered so everyone will have the same information on each residents status. 3.The Director of nursing will monitor the	

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F 688	Continued From page 27 He could not raise his left arm or open his left hand. A hand splint was on the bed side table. Resident #118 stated staff had not applied the splint in 3 months and his hand was contracting more. Resident #118 demonstrated how he exercised his left hand and wrist using his right hand to move the extremity. An observation and interview with Resident #118 on 4/21/2021 at 9:59 am revealed he did not have his hand splint on. Resident #118 stated therapy had evaluated him last week and they would be working on fitting him for his left-hand splint again. He stated his left hand had gotten much worse since the splint was not applied. During an interview with Nurse #2 on 4/21/2021 at 10:45 am she stated she was not aware Resident #118 had a left-hand splint. Nurse #2 stated there was not an order for the splint and the splint was not included on the plan of care. An interview was conducted with Nurse Aide #4 on 4/21/2021 at 10:58 am and she stated Resident #118 has a contracture to his left hand and cannot move his hand. Nurse Aide #4 stated Resident #118 has not had a splint since he was admitted to the facility. On 4/21/2021 at 12:50 pm the Therapy Manager was interviewed and stated Resident #118 had been evaluated and was scheduled to start therapy 4/22/2021 for Occupational Therapy to manage his contractures. The Therapy Manger stated Resident #118 was discharged by Occupational Therapy on 7/29/2020 with a splint for 8 hours a day to his left hand. The Therapy Manager stated nursing staff were educated on how to apply the splint and how long it should be	F 688	application of splints,the documentation and completion of all task by cna. The careplan for all current residents will be revised to reflect all residents that were identified and to ensure the care plan is updated and correct, and that the task is flagging for the cna's. 4.The application of splints and or assistive devices will be audited by the Director of nursing and or administrative nurses 5 x a week x 4 weeks, then once weekly x 4 weeks, then monthly until compliance is achieved. 5.Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement Committee by MDS coordinator monthly x 3 months. At that time, the Quality Assurance and Performance Improvement committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. completion date 5-19-21	

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F 688	Continued From page 28 left on when Resident #118 was discharged from therapy. The Director of Nursing was interviewed on 4/22/2021 at 12:24 pm and stated Resident #118 should have an order for the left-hand splint. The Director of Nursing also stated the order should have gone to the Director of Nursing and the MDS Nurse when Resident #118 was discharged from Occupation Therapy. The Director of Nursing stated after the MDS Nurse received orders for applying the left-hand splint for Resident #118 she should enter it into the electronic charting which would make it available to all nursing staff on the plan of care. During an interview with the Administrator on 4/22/21 at 12:49 pm she stated the nursing staff should have put Resident #118's left hand splint on per therapy's directions.	F 688		
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.	F 812		5/19/21

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F 812	Continued From page 29 §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 ensure 7 of 15 dishware were dry before stacked and ready for use. The facility additionally failed to discard 26 of 30 expired milk cartons stored in 1 of 2 refrigeration units. These practices had the potential to affect food served to residents. Findings included: The initial tour of the kitchen was conducted on 4-19-21 at 10:30am with the Dietary Manager. The tour revealed the following: a. 3 metal cooking pans stored on the shelf ready for use were stacked wet b. 4 meal trays stored at the steam table ready for lunch service were stacked wet c. 26 eight-ounce milk cartons stored in the reach in cooler at the tray line for lunch service had expired 3-28-21. The Dietary Manager was interviewed on 4-19-21 at 10:40am. The Manager explained it was staff's responsibility to make sure items opened were resealed and dated. She also discussed the drying racks for the cooking pans and meal trays. The Dietary Manager stated she did not know why the items were placed on the serving line or on the shelf wet. She commented staff had not rotated the milk products in the reach in cooler	F 812	F 812 1. The plan of correction for the specific deficiency On April 19,2021 is to Address how the facility will identify other residents having the potential to be affected by the same deficient practice; no individuals were affected by this pratice,all residents have the potential to be affected. a. 3 metal cooking pans stored on the shelf ready for use were stacked wet b. 4 meal trays stored at the steam table ready for lunch service were stacked wet c. 26 eight-ounce milk cartons stored in the reach in cooler at the tray line for lunch service had expired. During the lunch observation on 4-21-21 at 11:30am, the following observations were made: a.6 meal trays stored at the steam table ready for the lunch service were stacked wet b. 12 plastic plate bases stored at the steam table ready for the lunch service were stacked wet. 2.On 04/22/2021 the dietary manager re-educated current dietary staff that it is their responsibility to label all food and	

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F 812	Continued From page 30 causing expired milk to be left in the cooler. During the lunch observation on 4-21-21 at 11:30am, the following observations were made: a.6 meal trays stored at the steam table ready for the lunch service were stacked wet b. 12 plastic plate bases stored at the steam table ready for the lunch service were stacked wet. The Assistant Dietary Manager was interviewed on 4-21-21 at 11:35am. The Assistant Dietary Manager acknowledged the items had been stacked wet. The Assistant Dietary Manager removed the meal trays and plastic bases from the tray line. An interview with the Dietary Manager occurred on 4-22-21 at 11:00am. The Dietary Manager explained the kitchen was not well ventilated causing washed items not to dry completely. She also discussed the kitchen had a fan to assist in the drying process but had been removed during the COVID19 outbreak in the building. The Manager stated she had the fan replaced in the kitchen today (4-22-21) to aide in the drying process. The Administrator was interviewed by telephone on 4-26-21 at 9:26am. The Administrator discussed the fan in the kitchen had been removed causing washed items not to dry completely. She stated the fan had been replaced and that the washed items would be drying quicker.	F 812	check all dates on food prior to placing in the coolers and in the food service line. After 04/23/2021,. This education will be part of the orientation education for all newly hired dietary employees. 3.Beginning on 05/17/2021 an inservice was done to educate the dietary staff on the correct storage of kitchen pots,pans,trays ,and dishes to ensure no wet stacking.The industrial fan was replaced to help dry items after washing,daily audits will be done to check the drying equipment in the kitchen and to check the cooler for correct dating and labeling of food by the dietary manger or cook. 4. The facility plans to monitor its performance to make sure that solutions are sustained The daily rounds sheets will be reviewed by the administrator, and/or the Director og nursing. 5 times a week for 4 weeks,then 3 times a week x 3 weeks,and monthly x 3 months to ensure all areas remain in compliance. 5.The results of this review will be reported to the Quality assurance Performance improvement committee for any additional monitoring or modifications for three months. completion date 5-19-21	