STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345335	A. BUILDING ______ B. WING ______	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN OAKS NURSING AND REHABILITATION CENTER	**1704 NC HIGHWAY 39 N** **LOUISBURG, NC 27549**

(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 An unannounced recertification survey was conducted 4/15/24 through 4/18/24. The facility was found to be in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 6JWS11.	E 000		
F 000	INITIAL COMMENTS A unannounced recertification survey was conducted 4/15/24 through 4/18/24. Event ID #6JWS11.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment	F 553		5/14/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/08/2024

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

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F 553	Continued From page 1 and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to invite the resident to participate in the care planning process for 1 of 26 residents whose care plans were reviewed (Resident #84). The findings included: Resident #84 was admitted to the facility on 10/28/23. The care plan general note dated 11/08/23 by Social Worker #1 revealed a care plan meeting was held with Resident #84's Responsible Party (RP). Review of the care plan general note dated 1/25/24 by Social Worker #2 revealed Resident #84's RP was invited to participate in a care plan meeting but had not responded to the invite. A message was left for Resident #84's RP to return the call to review the care plan via telephone. Review of the progress notes from 1/25/24 through 4/16/24 revealed no documentation regarding Resident #84 being invited to attend a care plan meeting or that a care plan meeting was held.	F 553	F553 Right to Participate in Care Planning Resident #84 continues to reside in the facility. On 04/22/24 a care plan meeting was held with Resident # 84 and the Interdisciplinary Team (IDT), including the Social Worker, Activities Director, Unit Manager, and the Dietary Manager. The social worker gave Resident #84 a hand delivered invitation on Friday, 4/19/24 with documentation in the electronic record. On 4/18/24, the Social Worker initiated an audit of 100% of residents to ensure a written invitation was given for care plan meetings. The audit will be completed by 5/14/24. On 4/18/24, the Nurse Consultant initiated an in-service with the administrator, director of nursing (DON), Minimum Data Set (MDS) nurses, and social worker regarding Resident Care Plan Process with emphasis on (1) resident right to participate in the planning process (2) providing the resident and/or resident representative a written invitation to care plan meeting with documentation in the	

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F 553	Continued From page 2 The Minimum Data Set (MDS) quarterly assessment dated 3/08/24 revealed Resident #84 was cognitively intact. During an interview on 4/15/24 at 11:25 am, Resident #84 stated she had not been invited to attend a care plan meeting and did not recall participating in the development of her care plan. Resident #84 stated she wanted to attend the care plan meeting so she could discuss her goal to return home. An interview was conducted on 4/16/24 at 2:48 pm with Social Worker #1 who reported she did not recall participating in a care plan meeting with Resident #84 or the RP since her admission. She stated when she reviewed the care plan progress note dated 1/25/24 from Social Worker #2, she thought the care plan was reviewed with Resident #84, but she did not confirm that the care plan review occurred. Social Worker #1 stated the normal process was for Social Worker #2 to send the invitations to the RP to confirm they would be attending the scheduled care plan either in person or via telephone and when the care plan meeting was held a sign in sheet was completed with names of those in attendance. Social Worker #1 was unable to find any documentation that the care plan meeting took place from 1/25/24 to present and she was unable to state why a care plan meeting for Resident #84 was not held. Social Worker #1 stated she spoke with Resident #84 and the RP often but could not remember when the last care plan meeting took place. During an interview on 4/16/24 at 3:03 pm with Social Worker #2 she revealed she was responsible to send the invitations for care plan	F 553	electronic record. The in-service will be completed by 5/14/24. The MDS nurse will audit 10% of regulatory care plan meetings and/or scheduled quarterly reviews weekly x 4 weeks then monthly x 1 month to ensure a written invitation was given for care plan meetings with documentation in the electronic record. The Social Worker will address all concerns identified during the audit to include but not limited to providing a written invitation to the resident and/or resident representative with documentation in the electronic record and/or re-education of staff. The Administrator will review the care plan audit weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Care Plan Audit to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 553	Continued From page 3 meetings but did not hold the care plan meeting. Social Worker #2 stated she attempted to contact Resident #84's RP on 1/25/24 because she did not receive a response to the mailed care plan meeting invitation to set up a time to review the care plan over the phone with Social Worker #1. Social Worker #2 stated she documented in a progress note that she was unable to speak with Resident #84's RP but did leave a message regarding scheduling a time to review the care plan for Resident #84. Social Worker #2 stated she did not review the care plan with Resident #84 for the 1/25/24 planned care plan meeting. An interview was conducted with the Administrator on 4/17/24 at 2:37 pm, and she revealed Social Worker #1 was responsible to ensure Resident #84 was invited to the care plan meeting and that the care plan meeting was held as required.	F 553		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 637		5/14/24

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F 637

Continued From page 4

Based on record review and staff interviews, the facility failed to complete a Minimum Data Set (MDS) significant change assessment within 14 days for the use of a soft belt restraint for 1 of 1 resident reviewed for restraints (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 2/15/21 with diagnoses which included dementia.

The Physical Device Use Evaluation-Initial dated 12/29/23 revealed Resident #1 was evaluated for the use of a soft belt restraint for prevention of injury to self-characterized by high risk for injury and falls related to dementia and poor safety awareness.

Review of Resident #1's physician orders revealed an order dated 12/29/23 for soft belt restraint while up in chair for safety. Remove for activities, meals, and activities of daily living (ADLs) care.

The care plan dated 12/31/23 revealed Resident #1 had a physical restraint device (soft belt) in use for prevention of injury to self with interventions which included to remove during supervised activities and meals and re-apply upon completion.

The MDS significant change assessment with a completion date of 1/19/24 revealed Resident #1 was coded for use of a trunk (torso) restraint daily when in chair or out of bed.

An interview was conducted on 4/17/24 at 11:38 am with the MDS Nurse who reported the significant change assessment was to be

F 637

F637 Comprehensive Assessment after Significant Change

Resident #1 still resides in the facility. A significant change assessment for the use of a soft belt restraint was completed for Res #1 on 1/19/24 by the MDS Nurse.

The DON completed an audit on 05/03/24 of current residents meeting the criteria requirements of the 14-day Significant Change completion date to ensure a significant change assessment was completed as indicated. Any issues identified were corrected immediately by MDS Nurse.

The RAI/MDS Consultant re-educated the Minimum Data Set (MDS) nurses on 5/07/24 regarding the Resident Assessment Instrument (RAI) manual requirement for significant change assessment. Education regarding the RAI manual's requirement for significant change assessment will be added to the orientation of newly hired MDS nurses going forward.

10% of residents with significant change related to include residents using soft belt restraints will be reviewed by the DON and ADON weekly x 4 weeks then monthly x 1 month utilizing the Change of Condition Audit Tool. MDS Accuracy Audit Tool. This audit is to ensure a MDS Comprehensive Assessment was completed within 14 days of a significant change. The Administrator nurse will address all areas of concern identified

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F 637	Continued From page 5 completed within 14 days of Resident #1's order for the soft belt restraint. The MDS Nurse stated the normal process was the significant change assessment was completed within 14 days of the significant change, but she was unable to state why Resident #1's significant change assessment was completed late. During an interview on 4/17/24 at 2:34 pm the Administrator stated the MDS Nurse was responsible to ensure the MDS assessment was completed on time for Resident #1's soft belt restraint.	F 637	during the audit to include assessment of the resident and re-education of staff. The Director of Nursing (DON) will review the MDS Accuracy Audit Tool weekly x 4 weeks then monthly x 1 month to ensure completion and all areas of concerns were addressed. The Administrator will forward the results of the MDS Accuracy Audit Tool Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	
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 Minimum Data Set (MDS) assessment in the area of restraints for 1 of 1 resident reviewed for restraints (Resident #1). The findings included: Resident #1 was admitted to the facility on 2/15/21 with diagnoses which included dementia. Review of Resident #1's active physician orders revealed an order dated 12/29/23 for soft belt restraint while up in chair.	F 641	F641 Accuracy of Assessments On 4/16/24, the Minimum Data Set (MDS) Coordinator completed a modification of assessment for the cited error on the quarterly comprehensive assessment dated 3/28/24 for Resident #1 to reflect accurate coding for soft belt restraint for preventions of injury. On 4/18/24, the MDS Coordinator initiated an audit of the most recent comprehensive, significant change assessments and/or quarterly MDS	5/14/24

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F 641	Continued From page 6 The care plan dated 12/31/23 revealed Resident #1 had a physical restraint device (soft belt) in use for prevention of injury to self. The nursing progress note dated 3/25/24 at 3:56 pm revealed Resident #1 was in the wheelchair with the soft belt restraint applied. The nursing progress note dated 3/26/24 at 12:13 pm revealed Resident #1 was up in the chair with the soft belt restraint in place. The MDS quarterly assessment dated 3/28/24 revealed Resident #1 was not coded for the use of the soft belt restraint. An interview was conducted on 4/16/24 at 1:09 pm with the MDS Nurse who stated the MDS Nurse Consultant had completed Resident #1's quarterly assessment. The MDS Nurse stated the normal process to code use of the restraint was to observe the resident and review nursing notes to confirm the restraint was used. The MDS Nurse stated Resident #1 should have been coded for use of the soft belt restraint on the quarterly assessment. A telephone interview was conducted on 4/16/24 with the MDS Nurse Consultant who reported normally she reviewed nursing assessments or progress notes for the use of restraints to code the restraint on the assessment. The MDS Nurse Consultant stated she apparently missed the nursing notes for Resident #1's restraint use when she completed the quarterly assessment so the restraint was not coded. An interview was conducted on 4/17/24 at 2:36	F 641	assessment section P for all residents to include Resident #1 to ensure all MDS�s assessments completed are coded accurately for soft belt restraint. The DON will address all concerns identified during the audit to include updating assessments when indicated. The audit will be completed by 5/14/24. On 5/07/24, the MDS Consultant completed an in-service on MDS Assessments and Coding with all MDS nurses and MDS Coordinator regarding proper coding of MDS assessments per the Resident Assessment Instrument (RAI) Manual with emphasis on ensuring all MDS assessments are completed accurately for use soft belt restraint. All newly hired MDS Coordinator or MDS nurses will be in-serviced regarding MDS Assessments and Coding during orientation. 10% audit of completed MDS assessments section P, to include assessments for Resident #1, will be reviewed by the MDS consultant and/or Director of Nursing utilizing the MDS Accuracy Audit Tool weekly x 4 weeks then monthly x 1 month. This audit is to ensure accurate coding of the MDS assessment for use of soft belt restraint. All identified areas of concern will be addressed immediately by the MDS consultant and/or DON to include retraining of the MDS nurse and completing necessary modification to the MDS assessment. The DON will review the MDS Accuracy Audit Tool weekly x 4	

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F 641	Continued From page 7 pm with the Administrator who stated the MDS Nurse Consultant was responsible to ensure Resident #1's MDS quarterly assessment was coded accurately.	F 641	weeks and then monthly x 1 month to ensure any areas of concerns have been addressed. The DON will forward the results of MDS Accuracy Audit Tool to the QA Committee monthly x 2 months for review to determine trends and /or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Medical Director interview, the facility failed to maintain ongoing communication with the dialysis treatment center for 1 of 1 residents reviewed for dialysis (Resident #23). The findings included: Resident #23 was admitted to the facility on 6/27/23 with diagnoses which included end stage renal disease (ESRD), and dependence on dialysis. Resident #23 had an active physician order dated 3/12/24 for dialysis on Monday, Wednesday, and Friday.	F 698	F698 Dialysis Resident #23 no longer resides in the facility. On 4/18/24, the Assistant Director of Nursing (ADON) initiated an audit of all residents who receive dialysis to ensure the facility maintains ongoing communication with the dialysis treatment center to include but not limited to the completion of the Dialysis Communication Forms upon transfer to and return from the dialysis center. The ADON will address all concerns identified during the audit to include completion of dialysis communication forms and/or updating	5/14/24

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F 698	Continued From page 8 The care plan, last reviewed 3/29/24, revealed Resident #23 had ESRD and was at risk for complications related to dialysis with an intervention to communicate with dialysis treatment center. Review of Resident #23's dialysis communication notebook on 4/16/24 revealed 18 out of the 50 dialysis communication forms in the notebook were not completed by the facility staff prior to dialysis treatment for Resident #23. The 18 dialysis communication forms did not have the following information noted from the facility: name of resident, name of primary care physician, date, vital signs, medications administered prior to dialysis, diet, fluid restrictions, access site assessment, significant alerts, and name of facility nurse. An interview was conducted on 4/16/24 at 11:48 am with Nurse #1 who was assigned to Resident #23. Nurse #1 revealed he was assigned to Resident #23 on multiple dates when the dialysis treatment was scheduled. He stated Resident #23 had a dialysis communication form that the vital signs were written on prior to Resident #23 being transferred to the dialysis treatment center. Nurse #1 reviewed the blank dialysis communication forms and was unable to state if he was assigned to Resident #23 when the forms were not completed because there were no dates on the forms to confirm. Nurse #1 stated he knew about the dialysis communication forms and he normally put the vital signs on the form before Resident #23 went to dialysis, but he was unable to state why the forms were blank on the facility portion of the form.	F 698	dialysis treatment center forms when indicated and education of staff when indicated. The audit will be completed by 5/14/24. On 4/18/23, the Staff Facilitator initiated an in-service with all nurses regarding the Dialysis Communication Form with emphasis on completion of the dialysis communication form prior to and upon return from dialysis. In-service will be completed by 5/14/24. After 5/14/24, any nurse who has not worked or completed the in-service will complete it prior to the next scheduled work shift. All newly hired nurses will be in-service during orientation. The ADON will audit 10% of all charts of residents receiving dialysis weekly x 4 weeks then monthly x 1 month utilizing the Dialysis Audit Tool. This audit is to ensure the facility maintained ongoing communication with the dialysis treatment center to include but not limited to the completion of the Dialysis Communication Forms upon transfer to and from dialysis center. The ADON will address all concerns identified during the audit to include completion of dialysis communication forms and/or updating dialysis treatment center forms when indicated and retraining of staff when indicated. The DON will review the Dialysis audit weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON will present the findings of the	

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F 698	Continued From page 9 An interview was conducted on 4/16/24 at 11:54 am with the Unit Manager who revealed Resident #23's dialysis communication forms should be completed prior to dialysis and sent with the Resident. The Unit Manager stated he tried to check the dialysis communication notebook but did not do it consistently and he was unable to state why Resident #23's dialysis communication forms were not completed. A telephone interview was conducted on 4/16/24 at 12:10 pm with Nurse #2 who revealed she was assigned to Resident #23 every Friday. Nurse #2 stated the dialysis communication notebook was sent with the resident when they went to dialysis and the communication forms were supposed to be completed by the nurse before going to dialysis. Nurse #2 stated she did her best to complete the dialysis communication forms for Resident #23 before dialysis, but she was unable to state why the forms were not completed. An interview was conducted on 4/16/24 at 12:35 pm with Nurse #3 who revealed she was assigned to Resident #23 on dialysis days but was unable to recall the exact dates. Nurse #3 stated the dialysis communication forms were supposed to be completed by the nurse and sent to the dialysis treatment center with Resident #23. Nurse #3 reviewed Resident #23's blank dialysis communication forms and was unable to state why the forms were not completed by the facility. During an interview on 4/16/24 at 1:03 pm Nurse #4 revealed she was assigned to Resident #23 on dialysis days. Nurse #4 stated she was aware of the dialysis communication forms that were supposed to be completed prior to dialysis and sent with Resident #23 but she stated at times	F 698	Dialysis Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 698	Continued From page 10 she was busy and did not fill the forms out. An interview was conducted on 4/16/24 at 1:39 pm with the Director of Nursing (DON) who revealed the dialysis communication forms were to be completed prior to Resident #23's dialysis treatment by the nurse that was assigned to their care. The DON reviewed Resident #23's dialysis communication forms and confirmed the forms were not completed by the facility. The DON stated the facility did not have a process in place to ensure the dialysis communication forms were being completed. An interview was conducted on 4/17/24 at 9:48 am with the Medical Director who stated the dialysis communication forms were important to communicate with the dialysis treatment center about the care of the resident and they should be filled out by the facility prior to the resident going to dialysis. During an interview on 4/17/24 at 2:31 pm the Administrator revealed the nurses assigned to Resident #23 on the dialysis treatment days were responsible for the completion of the dialysis communication forms.	F 698		
F 805 SS=E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on a lunch meal tray line observation,	F 805	F805 Food in Form to Meet Individual	5/14/24

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F 805	Continued From page 11 staff interviews and record review the facility failed to provide pureed food items with a smooth consistency. This failure had the potential to affect 21 of 21 residents who had diet orders for a pureed diet texture. The findings included: A review of the Order Listing Report dated 4/17/24 revealed 18 residents with diet orders for a pureed diet texture and 3 residents with an order for pureed meats. Review of the menus revealed the facility followed the National Dysphagia Diet (NDD) for residents with diet orders for a pureed diet texture. The NDD recorded a dysphagia pureed diet required all foods pureed and thickened, if necessary, to a pudding-like consistency, lump free, requiring little to no chewing. A continuous observation of the lunch meal tray line with the Nutrition Consultant on 3/12/24 from 11:57 AM - 12:01 PM revealed the pureed chicken pastry was placed on the steam table with a lumpy consistency. The Cook stated she was intending to serve these items at lunch meal today, and that she had prepared them. She stated the consistency should be smooth, like pudding. The Nutrition Consultant agreed that the pureed chicken and pureed carrots had visible lumps. He asked the Cook to further blend both pureed items. An interview was conducted with the Dietary Manager (DM) on 4/16/24 at 1:13 PM. He revealed that pureed foods should be a pudding-like consistency. The DM stated he had not observed lumpy consistency of pureed foods	F 805	Needs On 4/16/24, the facility removed the pureed food items and prepared new food items to ensure the consistency met pureed food requirements. The Dietary Manager immediately in-serviced the Dietary Cook on preparation of pureed food items with emphasis on pudding-like consistency, free of particles, without the need for chewing. On 04/17/24, the Dietary Manager completed an audit of all meal times to ensure the pureed food items met the requirements of pureed diet consistency that was pudding-like, free of particles, without the need for chewing. There were no concerns identified. On 4/16/24, the Dietary Manager initiated an in-service with all dietary cooks regarding preparation of pureed food with emphasis that is of a smooth pudding like consistency to ensure the consistency meets pureed requirements. After 4/16/24 any cook who has not worked or received the in-service will complete in-service prior to the next scheduled work shift. All newly hired cooks will be in-serviced during orientation regarding preparation of pureed diet consistency that should be pudding like, which is smooth without particles, without the need for chewing. The Dietary Manager and/or Assistant Dietary Manager will monitor the meal tray line for pureed consistency to ensure	

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F 805	Continued From page 12	F 805		

previously and did not receive any complaints on this issue. He indicated that the Cook had been cooking at the facility for the last 10 years, so perhaps she was nervous, or it was an oversight. The DM stated the Cook will receive re-education on puree consistency, but it was good that she corrected it in the moment.

During an interview with the Registered Dietitian (RD) on 4/17/24 at 12:26 PM, she revealed that the consistency of pureed foods should be like pudding. If residents on a puree diet were served foods with a lumpy consistency, they could possibly choke. She stated she had not noticed lumpy pureed foods at the facility and ordered pre-pureed rice, pasta, corn, and bacon due to high risk of inappropriate consistency with these foods.

The Speech Language Pathologist (SLP)/Rehab Manager was interviewed on 4/17/24 at 1:52 PM. She revealed that the puree diet consistency should be like pudding, which is smooth without particles without the need for chewing. If a lumpy consistency was served, it would not be considered pureed but more like mechanical soft. The risks would be pocketing (hold pieces that they cannot swallow in their cheek), and residents may get tired or have decreased strength due to more chewing. The SLP/Rehab Manager stated she had not witnessed pureed foods to have lumpy consistency at the facility.

The Administrator stated in an interview on 4/17/24 at 10:48 AM that if the pureed foods had lumps in them, then those dishes would need to be further blended to a proper puree consistency.

pudding-like consistency, free of particles, without the need for chewing 5 times a week x 4 weeks then monthly x 1 month.

The Administrator will present the findings of the Dietary Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 812	Continued From page 13	F 812		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to allow cook pans and dome lids to completely dry prior to assemblage and stacking for three of three observations. The facility also failed to clean the convection ovens. These practices had the potential to affect food served to residents. The findings included: 1. An observation of the kitchen and interview with the Dietary Manager (DM) was conducted on 4/15/24 at 9:58 AM. Twelve steam table pans were observed to be stacked wet and ready for reuse on a cart next to the 3-part sink. The DM	F 812	F812 Food Procurement, Store/Prepare/Serve- Sanitary On 4/18/24, the Dietary Manager removed all cook pans and dome lids found to be stacked without properly drying, re-washed and air-dried per facility protocol. On 4/18/24, the Dietary Manager cleaned the convection oven per facility protocol. On 4/18/24, the Dietary Manager verbally educated dietary staff to allow cook pans and dome lids to completely dry prior to	5/14/24

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F 812

Continued From page 14

stated the pans should be air dried and stacked at an angle to prevent wet nesting.

During a follow-up tour of the kitchen on 4/16/24 at 8:46 AM with the DM, three pans on the cart next to the 3-part sink were observed with wet nesting. The DM stated the wet pans were due to them falling on top of each other and not stacked at an angle to air dry.

An observation of the kitchen during lunch meal service on 4/16/24 at 12:27 PM revealed water dripped from a dome lid as a Dietary Aide took it from the rack and placed it on top of a plated meal. Fifty-two dome lids were observed with wet nesting on the inside edge. The DM stated they should be dry, but the water collected on the inside edge due to placement on the dry rack. He instructed the Dietary Aide to shake off the excess water before placed on top of the plate.

During a follow-up interview with the DM on 4/16/24 at 1:08 PM, he revealed the pans had slipped and fallen from their stacking position. The DM stated his staff had been trained on how to properly place clean pans to prevent wet nesting.

The Administrator was interviewed on 4/17/24 at 12:31 PM. She revealed that she went to the kitchen on 4/17/24 and noticed the water on the inside edge of the dome lids. She stated it was a manufacturer issue. However, when she purposely put water on the inside edge of one of the domes and placed it on top of a plate, she noticed the water did not touch the plate. The Administrator indicated there was a short period of time in between breakfast and lunch for dishes/pans to air dry. The Administrator revealed

F 812

assemblage and stacking; and clean the convection ovens weekly.

On 4/18/2024, an audit of all kitchenware was completed by the Payroll/Human Resources Director to ensure all kitchenware was dried completely prior to assemblage and stacking. The Administrator will address all concerns identified during the audit to include re-washing all kitchenware found to include pots and dome lids found to be assembled and stacked without completely drying and education of staff. The audit will be completed by 5/14/2024.

On 4/18/24, an audit was completed of all convection ovens to ensure all ovens were cleaned per facility protocol. The Dietary Manager will address all concerns identified to include cleaning ovens when indicated and education of staff. The audit will be completed by 5/14/24.

On 4/18/2024, the Dietary Manager initiated an in-service with dietary staff regarding Food Safety with emphasis on (1) allowing cook pans and dome lids to completely dry prior to assemblage and stacking and (2) cleaning the convection ovens weekly per facility protocol. The in-service will be completed by 5/14/24. After 5/14/24, any dietary staff who has not completed the in-service will complete it at the next scheduled work shift. All newly hired dietary staff will be in service during orientation.

The Assistant Dietary Manager will

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F 812 Continued From page 15
that there should not be any water on any clean dishes/pans for service. Staff needed to be re-educated on how the pans needed to be placed to ensure they were completely air dried.

2. An observation of the kitchen and interview with the DM were conducted on 4/15/24 at 9:58 AM. The convection oven had a thick, black layer on the bottom and brown grease covered both glass doors on the top oven. The bottom oven did not have the black substance, but grease covered both glass doors on the inside. The DM stated the ovens were due to be cleaned, and they were usually cleaned every few weeks.

An observation of the kitchen and interview with the DM were conducted on 4/16/24 at 11:43 AM. The inside of all glass doors was covered by brown grease. The top oven doors were cleaned slightly, and the black substance on the bottom of the top oven remained. The DM stated that staff started to clean the convention ovens.

During a follow-up interview with the DM on 4/16/24 at 1:09 PM, he revealed that the convention ovens should be cleaned fully by the end of the day. Kitchen staff began cleaning the ovens the night before.

The Administrator was interviewed on 4/17/24 at 12:33 PM. She stated that the black substance on the bottom of the top oven was part of the equipment itself and could not be scraped off. The Administrator indicated that the black substance might be due to overuse and was not present when ovens were new. She revealed that the convention ovens were supposed to be cleaned every two weeks, but that was changed

F 812
complete an audit of kitchenware and convection ovens weekly x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool to ensure staff (1) allowing cook pans and dome lids to completely dry prior to assemblage and stacking and (2) cleaning the convection ovens weekly. The Administrator will address all concerns identified during the audit to include re-washing all kitchenware to include pots and dome lids found to be assembled and stacked without completely drying, cleaning ovens when indicated and re-training staff. The Administrator will review the Kitchen Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.

The Administrator will present the findings of the Kitchen Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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F 812	Continued From page 16 to weekly. On 4/17/24 at 1:59 PM, the Administrator presented a piece of the black substance on the bottom of the top oven. She stated it seemed like plastic material caused by the degreaser that could be removed. The Administrator indicated that the convention ovens were not delivered with the black substance present.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		5/14/24

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F 842	Continued From page 17 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 18 Based on staff interviews and record review, the facility failed to maintain a complete and accurate medical record for 1 of 26 residents' medical records reviewed (Residents #79). The findings included: Resident #79 was readmitted to the facility on 3/21/24 with a diagnosis of dysphagia (difficulty swallowing). The medical record included no evidence of a signed waiver related to Resident #1's dietary status. An interview was conducted with Resident #79 on 4/15/24 at 11:13 AM. He revealed that he wanted to eat regular food and drink thin liquids and signed a waiver in the past to do so freely. On 4/16/24 at 1:20 PM, the Dietary Manager (DM) was interviewed. He stated that Resident #79 had mentioned to him recently that he signed a waiver to eat regular foods. The Speech Language Pathologist (SLP)/Rehab Director was interviewed on 4/16/24 at 3:29 PM. She revealed that Resident #79 previously signed a waiver (date unknown) to eat regular foods despite his NPO status. During a follow-up interview with the SLP/Rehab Director on 4/17/24 at 9:11 AM, she revealed that once the waiver was signed, it would be discussed in the interdisciplinary team (IDT) morning meeting and given to either the assigned Unit Manager or Medical Records to upload into the chart.	F 842	F842 Resident Records - Identifiable Information On 04/17/24, Resident #79 was educated by the facility physician regarding the risks, including aspiration and death, and the decision to go against medical advice of nothing by mouth (NPO) status. Resident #79 signed an Against Medical Advice (AMA) waiver to allow for PO intake. The AMA waiver was scanned in the medical record. On 04/18/24, DON completed an audit of all medical records for residents with waivers to include Resident #79. This audit is to ensure that all waivers are scanned into the electronic record and that the medical record is accurate and complete. The DON will address all concerns identified during the audit to include updating medical records for all newly identified waivers when indicated and education of staff. On 4/18/2024 DON in-serviced the medical records staff regarding maintaining complete and accurate medical records with emphasis on ensuring waivers are scanned into the electronic record to ensure medical records are accurate and complete. After 4/18/2024 any newly hired medical record staff will be in-service during orientation. The DON will audit all newly written medical waivers weekly x 4 weeks then monthly x 1 month utilizing the Medical Record Audit Tool. This audit is to ensure	

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F 842	Continued From page 19 An interview was conducted with the Registered Dietitian on 4/17/24 at 9:42 AM. She revealed that Resident #79 was presented with a waiver to discuss the benefits/risks of by mouth intake or going against medical advice. The Director of Nursing (DON) was interviewed on 4/17/24 at 9:14 AM. She revealed that she was aware Resident #79 had a signed waiver in place provided by the SLP/Rehab Manager and the MD was aware of Resident #79's signed waiver for regular foods/liquids. Once the waiver was signed, Medical Records should have uploaded it to Resident #79's chart. During an interview with the Medical Director (MD) on 4/17/24 at 10:00 AM, he revealed that the waiver form was to make sure the resident understood and was aware of the risks of their decision to go AMA. He was aware that Resident #79 signed a waiver to eat regular foods. The Administrator was interviewed on 4/17/24 at 10:42 AM, and she revealed that the purpose of the signed waiver was for education only to notify Resident #79 of the risks/benefits of his actions when he ate and aspirated. Review of the signed waiver by Resident #79 dated 4/17/24 revealed that he understood the risks and wished to go AMA for his dietary order.	F 842	waivers are scanned into the medical record and the medical record is accurate and complete. The DON will address all concerns identified during the audit to include updating medical records for all newly identified waivers when indicated and re-training of staff. The Administrator will review the audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will present the findings of the Medical Records Audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months for review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data	F 867		5/14/24

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F 867	Continued From page 20 collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions	F 867		

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F 867	Continued From page 21 aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The	F 867		

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F 867	Continued From page 22 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the 2/4/22 recertification and complaint investigation survey. This was for one deficiency previously cited in the area of infection prevention and control (F880). This deficiency was recited during the facility's current recertification survey	F 867	F867 QAPI/QAA Improvement Activities On 4/18/24, the Facility Consultant initiated an audit of previous citation and action plan from 2/04/22 to present related to F880 Infection Control to ensure the Quality Assurance (QA) committee has maintained and monitored interventions that were put into place. Action plans were revised and updated	

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Continued From page 23

of 4/18/24. The continued failure of the facility during 2 federal surveys shows a pattern of the facility's inability to sustain an effective QAA Program.

The findings included:

The tag is cross referenced to:

F880: Based on observations, record review, and staff interviews, the facility failed to handle visibly soiled and wet linen to avoid contamination of staff clothing for 1 of 1 laundry aides observed (Laundry Aide #1).

During the facility's recertification and complaint investigation survey of 2/4/22 the facility failed to follow the Centers for Disease Control and Prevention (CDC) guidelines for personal protective equipment (PPE) when a staff member was observed entering a quarantine room without wearing gloves and a gown

An interview was completed on 4/18/24 at 9:30am with the Administrator and Director of Nursing. The Administrator indicated the QAA committee met monthly to discuss the facility's ongoing performance improvement plans. The Administrator indicated there were no current monitoring plans in place for infection prevention and control. The Administrator indicated it was her expectation the facility continued to follow the QAA process and monitor those issues within the facility so they would not receive a recited deficiency.

F 867

and presented to the QA Committee by the Administrator for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to the education of staff. The audit will be completed by 5/14/24.

On 5/07/24, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and assistant Director of Nursing and Unit Managers regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include infection control practices. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 5/14/24. All newly hired Administrator, DON and ADON will be educated during orientation regarding the QA Process.

All data collected for identified areas of concerns, to include F880 Infection Control will be taken to the Quality Assurance committee for review monthly x 3 months by the Director of Nursing. The Quality Assurance committee will review the data and determine if a plan of correction is being followed, if changes in plans of action are required to improve

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F 867	Continued From page 24	F 867	outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the DON. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the QA Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include F880 Infection Control and all current citations and that the QA plans are followed and maintained Quarterly x 1. The Facility Consultant will immediately retrain the Administrator, DON and Unit Managers for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Director of Nursing to the Committee Quarterly x 1 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/14/24

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§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable

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F 880	Continued From page 26 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to handle visibly soiled and wet linen to avoid contamination of staff clothing for 1 of 1 laundry aides observed (Laundry Aide #1). The findings included: Review of the facility policy titled "The Infection Prevention and Control Program (IPCP)" dated April 2023 revealed the facility was to establish and maintain an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. Review of the facility policy titled "Laundry Infection Control Responsibilities" dated April 2023 revealed soiled linen may contain germs	F 880	F880 Infection Prevention & Control The Housekeeping Manager in-serviced the laundry assistant on 4/17/24 with return demonstration on proper donning and doffing personal protective equipment (PPE) for handling with visibly soiled linens and wet linens to avoid contamination of staff clothing. The Housekeeping Manager completed an audit on 04/17/24 of laundry staff handling visibly soiled and wet linens to ensure proper avoidance of contamination of staff clothing to ensure the problem does not recur. The Housekeeping Manager initiated an Inservice for laundry staff on 4/17/23 with	

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F 880	Continued From page 27 that are capable of causing possible infections. The policy further read to "always wear personal protective equipment (PPE) when handling soiled linen which included an apron or gown to protect your clothing and gloves." A continuous observation on 4/17/24 from 8:18 am through 8:28 am revealed Laundry Aide #1 pushed a laundry bin from the soiled linen area to the washing machine with gloved hands and removed visibly soiled and wet linen from the laundry bin and placed the items in the washing machine. The Laundry Aide #1 was then observed to lean her upper body to the waist into the laundry bin to remove the remainder of the visibly soiled and wet linen from the laundry bin with the front and sleeves of her uniform touching the top and interior of the laundry bin. The empty laundry bin was then pushed to the soiled linen area, and it was observed to have multiple areas of brown substance on the interior upper portion of the laundry bin. Laundry Aide #1 returned from the soiled linen area with a second laundry bin and placed the visibly soiled and wet linen into the washing machine with gloved hands. Laundry Aide #1 did not wear an apron or gown while handling the soiled and wet linens and no aprons or gowns were observed in the laundry area. An immediate interview was conducted on 4/17/24 at 8:28 am with Laundry Aide #1 who revealed she only used gloves when handling soiled linens and she removed the gloves after sorting the laundry and then used hand sanitizer. She stated she did not use any other PPE when handling or sorting laundry. A follow-up interview was conducted on 4/17/24 at 10:00 am with Laundry Aide #1who stated the	F 880	return demonstration on proper donning and doffing personal protective equipment (PPE) for handling visibly soiled linens and wet linens to avoid contamination of staff clothing to ensure protection of residents in similar situations. The Inservice will be completed by 5/14/24. On 4/18/2024, the Infection Control Preventionist initiated an in-service with return demonstration to ensure laundry staff are properly donning and doffing personal protective equipment (PPE) for handling visibly soiled and wet linens to ensure proper avoidance of contamination of staff clothing. The in-service will be completed by 5/14/24. After 5/14/24, any laundry staff who have not completed the in-service will complete it at the next scheduled work shift. All newly hired laundry staff will be in serviced during orientation to include return demonstration of proper donning and doffing PPE. The Infection Control Preventionist, and Housekeeping Director will observe 5 staff weekly x 4 weeks then monthly x 1 month to ensure laundry staff are properly donning and doffing personal protective equipment (PPE) for handling visibly soiled and wet linens to ensure proper avoidance of contamination of staff clothing utilizing the PPE Audit Tool. This audit is to ensure staff are utilizing appropriate PPE when handling visibly soiled and wet linens. The Infection Control Preventionist will address all areas of concern during the audit to include providing use of appropriate PPE	

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F 880	Continued From page 28 facility had given her a gown to wear one day when she was doing the laundry, but gowns had not been provided for use again. Laundry Aide #1 stated she was not educated that a gown or apron was supposed to be worn when handling the soiled linens and she stated she did not know where to locate a gown or an apron to use. During an interview on 4/17/24 at 10:04 am with the Housekeeping Manager, she revealed that only gloves were required to be worn when handling soiled linens. She stated if the linen was very soiled the staff had the option to wear a gown if they wanted to, but she was not aware of a requirement to wear a gown on when handling soiled linens. The Housekeeping Manager stated the Infection Preventionist (staff member responsible for the facility's IPCP) had provided education to the staff in laundry, but she did not recall being told gowns were required when sorting soiled linens. An interview with the Infection Preventionist (IP) was conducted on 4/17/24 at 10:11 am who revealed the laundry staff should wear gloves when handling the dirty linen. She stated that the education she provided to the laundry staff was that gloves were to be worn when working with soiled linen, no other PPE was needed for soiled or regular linen. The IP was unable to recall when the education for the laundry staff was conducted. A follow-up interview was conducted on 4/17/24 at 10:55 am with the IP who clarified the education that was provided to the laundry staff included the use of gowns when handling soiled linen. The IP stated she must have misunderstood when asked about what PPE	F 880	and/or re-education of staff. The DON will review and initial the results of the PPE Audits to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months to review the PPE Audit Tool for trends and/ or issues and to determine the continued need and frequency of monitoring.	

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F 880	Continued From page 29 laundry staff were required to use when handling soiled linen. An interview was conducted on 4/17/24 at 2:19 pm with the Director of Nursing (DON) who revealed she would have to review the policy and speak with the IP regarding the requirements for laundry staff handling soiled linen. During an interview on 4/17/24 at 2:25 am the Administrator stated Laundry Aide #1 should have worn a gown when handling soiled linen if the policy stated it was required. A follow-up interview on 4/18/24 at 8:20 am with the Administrator and DON revealed the policy had been reviewed and the laundry staff had been educated in the proper use of PPE when handling soiled linen.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to maintain an effective pest control program as evidenced by observations of fly activity in the kitchen on 3 different occasions. The facility failed to utilize insect light traps and implement pest service recommendations to prevent reoccurring pest activity. This practice had the potential to affect residents in the facility. The findings included:	F 925	F925 Maintains Effective Pest Control The kitchen was treated by the facility's pest control contractors during an additional visit on 4/15/24. The Maintenance Director installed new kitchen drain covers for two of the four drain covers on 4/17/24. On 4/18/24, the Dietary Manager initiated an audit of all drain covers in the kitchen	5/14/24

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Review of the Pest Control Service Agreement without a date revealed the following pests were covered by the contract: roaches, rodents, ticks, ants (except carpenter), crickets, fleas, spiders, ground beetles, earwigs, silverfish, and stored product pests.

Observations of live pest activity occurred on the following:
- 4/15/24 at 10:00 AM: 3 flies observed at the entrance to the drain in the middle of the kitchen in between the steamer and convention ovens. The Dietary Manager (DM) was present and stated the cover to the drain cracked, and a new one has been ordered.
- 4/16/24 at 11:51 AM: 1 fly observed on overhead light above steam tray line.
- 4/16/24 at 12:22 PM: 1 fly observed flying around steam table during lunch meal service

On 4/16/24 at 3:45 PM, two wall mounted insect light traps were observed unplugged at the front entrance across from the dining room and on the administrative hall adjacent to the front entrance. The Maintenance Director was seen servicing both light traps at the time.

The DM was interviewed on 4/16/24 at 1:10 PM. He revealed that the kitchen was sprayed for pests monthly. The DM stated that he had not observed flies in the kitchen before, but now that the temperature was increasing, there would be more fly activity. He indicated that he would call the pest control company for the observance of the flies within the last 2 days. The DM presented an invoice for drain covers ordered on 4/15/24.

During an interview with the Maintenance Director

to ensure they were in good working order. All concerns will be addressed by the Maintenance Director. This audit will be completed by 05/14/24.

On 4/18/24, the Dietary Manager initiated an audit of the fly lights in the building to ensure they were working properly and in good order. All concerns will be addressed by the Maintenance Director. This audit will be completed by 5/14/24.

On 4/18/24, the Dietary Manager initiated an in-service with Maintenance staff regarding ensuring fly lights are turned on and in working order and drain covers are intact to ensure that the problem does not recur. The in-service will be completed by 5/14/24. After 5/14/24, any Maintenance staff who have not completed the in-service will complete it at the next scheduled work shift. All newly hired maintenance staff will be in-serviced during orientation.

The Dietary Manager will audit kitchen drain covers 2 x week x 4 weeks to ensure they are in good working order. The Dietary Manager will audit the fly lights in the building 2 x week x 4 weeks to ensure they are working properly and in good order. All concerns will be addressed by the Maintenance Director.

The Administrator will present the findings of the Drain Cover and Fly Light Audits to the Quality Improvement Assurance Committee monthly x 2 months for review to determine the need for further

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F 925	Continued From page 31 on 4/17/24 at 11:09 AM, he revealed that the pest control company visited monthly to spray areas of the facility and lay down traps. He indicated that a fly spray was used during the monthly visits. He heard about the flies in the kitchen on 4/15/24 and had not received any complaints about flies previously.The Maintenance Director stated that the fuses blew at least once monthly in both insect light traps outside of the dining room and on administrative hall. He stated the traps were working last week, and they were serviced on 4/15/24 and were now operable. The Maintenance Director indicated that an indoor fly spray was purchased on 4/15/24. The back service hall outside door was used frequently and flies entered through that door. He stated that the insect light trap in the back service hall was knocked down by a meal cart about 2 weeks ago, and it was replaced on 4/15/24. He had observed flies in the back service hall next to the kitchen since the trap was knocked down. The Maintenance Director indicated the pest control company was asked to service the facility on 4/15/24 outside of the monthly visits, and he sprayed outside the service door where the trash was located as well as the service loading dock. On 4/17/24 at 12:36 PM, the Administrator was interviewed. She revealed that when she went into the kitchen on 4/16/24, she saw a few flies flying around. The Administrator stated that the meal carts were hard to control in the service hallway, and the fly light trap kept getting knocked down. She had 3 new fly light traps installed on 4/16/24, including the traps outside of the dining room, on the administrative hallways, and the back service hall. The Administrator indicated that the pest control company came out yesterday to spray extra around doors, windows, and traffic	F 925	frequency of monitoring.	

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F 925	Continued From page 32 areas. She stated that a kitchen/building with multiple doors was difficult to be fly-free. They controlled it the best they could with tactics including pest control, fly lights, manual fly swatters, and education to staff to not leave the doors open.	F 925		