STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 05/22/2024

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LAUREL PARK REHABILITATION AND HEALTHCARE CENTER	901 HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/19/24 through 5/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #QPWN11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/19/24 through 5/22/24. Event ID# QPWN11. The following intakes were investigated: NC00204322, NC00208963, NC00206761, NC00208443, NC00203556, NC00206670, NC00207801, NC00212452, NC00211326, NC00204823, NC00213914, NC00213730, and NC00215471. 1 of the 64 complaint allegations resulted in deficiency.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		6/19/24

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

Electronically Signed | 06/11/2024

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F 655	Continued From page 1 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement an individualized person-centered baseline care plan that included the use of insulin (a medication used to lower the blood glucose [sugar] in the blood) and anticoagulants (a medication use to prevent clotting of the blood) for 1 of 5 residents reviewed for unnecessary medications (Resident #293). Findings included:	F 655	1. Resident #293 no longer resides at the facility. 2. All Residents have the potential to be affected by the deficiency. An Audits were completed by 6/11/24 by ADON to ensure residents baseline care plan reflects the insulin and anticoagulants as ordered. 3. The DON or designee has educated all licensed staff that residents that require insulin or anticoagulants have a person centered baseline care plan in place	

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F 655	Continued From page 2 Resident # 293 was admitted to the facility on 5/10/2024 with diagnoses including Diabetes Mellitus, pulmonary embolism (blockage of a blood vessel) and deep vein thrombosis (blood clot in the blood vessel). Physician's orders dated 5/10/2024 included Apixaban (a medication used to thin the blood) 5 milligrams (mg) twice a day and Humalog 100 units per milliliter sliding scale insulin subcutaneously (under the skin) before meals for blood glucose readings: 0 -150 give 0 units; 151 - 200 give 2 units; 201 - 250 give 4 units; 251 - 300 give 6 units; 301 - 350 give 8 units; 351 - 400 give 10 units and call MD if over 400. The admission Minimum Data Set (MDS) assessment dated 5/12/2024 and was recorded as in progress. Medications on the MDS assessment were not completed. Resident #293's May 2024 electronic Medication Administration Record (MAR) recorded Apixaban was administered twice a day and Humalog sliding scale insulin was administered three times from 5/10/2024 to 5/13/2024. The baseline care plan form dated 5/13/2024 indicated Resident #293 was cognitively intact and had a diagnosis of Diabetes Mellitus. The medication section included a place to indicate when insulin or anticoagulant medications were received, but these were not marked. In an interview on 5/21/2024 at 2:54 p.m. with Nurse #3, she stated Resident #293 was receiving the medications, Apixaban and Humalog insulin, on admission and both of these	F 655	completed on date 6/13/24. In addition, new hire nursing staff will be educated in orientation to ensure that know that resdeints who require insulin or anticoagulants have person centered care plans. 4. The DON or Designee will audit weekly 4 residents weekly for two weeks and then 4 residents monthly for 3 months to ensure that baseline care plans reflect the individual needs of insulin and anticoagulation; these results will be reviewed during the Quality Assurance Performance Improvement (QAPI) Committee meeting and take further action as necessary.	

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F 655	Continued From page 3 medications should have been marked on her baseline care plan. She said she did not have a reason why she did not mark Resident #293 was taking insulin and an anticoagulant on the baseline care plan. In an interview on 5/21/2024 at 2:49 p.m. with the Assistant Director of Nursing, she stated she reviewed Resident #293's baseline care plan and signed the information was correct on Resident #293's baseline care plan. She explained based on the physician's orders for Apixaban and Humalog insulin, Resident #293's baseline care plan was not accurate, and insulin and anticoagulant medications should have been marked on the baseline care plan. In an interview on 5/22/2024 at 9:18 a.m. with the Director of Nursing, she explained when Nurse #3 completed the baseline care plan the medications, Insulin and Apixaban, should have been marked since Resident #293 had an order for the medications and was receiving the medications. She stated during Resident #293's 72-hour care plan meeting the baseline care plan was reviewed and could have been corrected if identified as inaccurate during the care plan meeting.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		6/19/24

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F 656	Continued From page 4	F 656		

medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 5 Based on record review and staff interviews the facility failed to implement an individualized person-centered care plan for a resident with impaired vision for 1 of 5 residents reviewed for nutrition (Resident #36). The findings included: Resident #36 was readmitted to the facility on 12/15/23. A physician order dated 2/27/24 for Resident #36 revealed that all food was to be placed in individual bowls at all meals to increase with self-feeding secondary to decreased vision. The Minimum Data Set (MDS) Annual Assessment dated 4/12/24 revealed Resident #36 was cognitively intact, had highly impaired vision, and required setup help for eating. Review of Resident #36's active care plan (last revised on 2/27/24) revealed she had malnutrition risk related to history of coronary artery disease, stroke, mixed hyperlipidemia, vertigo, and hypertension. Interventions included: provide food in bowls to assist with completion of meals related to visual deficits. An observation on 5/20/24 at 12:24 PM revealed Resident #36 was observed to have the lunch meal served on a flat plate. The meal ticket stated all food was to be served in bowls. Only the dessert item was placed in a bowl. Resident #36 stated that her lunch meal should have been served in bowls. A new meal placed in bowls was offered to Resident #36, but she declined. An observation and interview with the Director of	F 656	1. Resident # 36 was given food in bowls as implemented by the care plan for impaired vision on 5/20/24. 2. All Residents have the potential to be affected by the deficiency. An Audits was conducted on 6/13/2024 by the MDS nurse to ensure residents with impaired vision have an implemented interventions for adaptive equipment with eating. 3. The Administrator has educated dietary staff that residents with impaired vision have adaptive equipment with eating as implemented by the care plan on 6/14/2024. In addition, new hire dietary staff will be educated in orientation to ensure that residents that have adaptive equipment recommendations in their care plan are provided with the appropriate devices as per their care plan. 4. The Administrator will audit five residents with impaired vision have adaptive equipment as implemented by the care plan weekly for two weeks and monthly for 3 months; these results will be reviewed during the Quality Assurance Performance Improvement (QAPI) Committee meeting and take further action as necessary.	

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F 656	Continued From page 6	F 656		

Rehab took place on 5/20/24 at 9:20 AM, and he confirmed that Resident #36's lunch meal was served on a flat plate. The Director of Rehab stated that he had ordered all food for all meals to be served in bowls, so that Resident #36 had an easier time eating due to blindness in both eyes. He further stated that the food should have been served in separate bowls because Resident #36 could not see the food items. The Director of Rehab indicated that he notified the previous Dietary Manager (DM) back in February 2024 about the new order for adaptive equipment. He stated he was going to go to the kitchen and notify the current DM that Resident #36's lunch was not served in bowls.

On 5/21/24 at 10:03 AM, Nurse Aide (NA) #1 was interviewed. She stated that Resident #36's food was usually served in bowls, and if not, she would notify the kitchen. NA #1 confirmed that she saw Resident #36's lunch meal was not served in bowls, but the Director of Rehab went to the kitchen to notify the staff before she could.

During an interview with the MDS Nurse on 5/21/24 at 1:28 PM, she revealed that Resident #36's care plan included meals should be served in bowls due to impaired vision. She stated that nursing staff should have double checked Resident #36's lunch meal before it was served to her. The MDS Nurse indicated that Resident #36 should have received food in bowls to make eating easier for her due to highly impaired vision as stated in the care plan.

An interview was conducted with the Director of Nursing (DON) on 5/21/24 at 1:36 PM. She stated that if Resident #36's meal was not served in bowls as stated in the care plan, the nursing staff

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F 656	Continued From page 7 should have ensured the meal served was as ordered. The Administrator was interviewed on 5/21/24 at 1:56 PM. She stated that that the plan of care should have been followed, and Resident #36's lunch meal should have been provided in bowls.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		6/19/24

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F 657	Continued From page 8 by: Based on record review, resident interviews and staff interviews, the facility failed to conduct and document a care plan meeting with a cognitively intact (Resident #86) and moderately impaired (Resident #38) residents newly admitted to the facility and failed to conduct and invite a cognitively intact resident to participate in care plan meetings after two annual Minimum Data Set (MDS) assessments and three quarterly MDS assessments (Resident #26) for 3 of 6 residents reviewed for care planning. Findings included: 1. Resident # 86 was admitted to the facility on 5/2/2024 with diagnoses including multiple fractures. The admission Minimum Data Set (MDS) assessment dated 5/4/2024 indicated Resident #86 was cognitively intact. Resident #86's baseline care plan was signed by the Assistant Director of Nursing as completing the plan on 5/3/2024. The MDS Nurse signature was not dated and the Director of Nursing signed the baseline care plan on 5/21/2024. Resident # 86's comprehensive care plan dated 5/4/2024 indicated he was on pain medication due to fractures of the humerus and femur bones. On 5/9/2024, the care plan was updated to include a focus indicating Resident #86 had acute pain post a fall resulting in a humerus and femur fracture. In an interview with Resident #86 on 5/19/2024 at 11:49 a.m., he stated the facility had not held a	F 657	1.Resident #86 and Resident #38 care plan meeting was completed on 6/13/2024. 2. All Residents have the potential to be affected by the deficiency. An Audits was conducted on 6/11/2024 by the SW to ensure residents have had a care plan meeting within the last 90 days. 3. The Administrator has educated the IDT team that residents have a care plan meeting after a quarterly or comprehensive MDS assessment completed on date 6/14/2024.In addition, new hire IDT staff members will be educated in orientation to ensure that residents have a care plan meeting after a quarterly or comprehensive MDS assessment completed. Initial Care plan meetings are scheduled by the Admission Director after Admission, social services schedules, organizes and documents the care plans meetings. 4. The Administrator will ensure that a care plan meeting is completed after a quarterly or comprehensive MDS assessment on five residents weekly for 2 weeks and monthly for three months, these results will be reviewed during the Quality Assurance Performance Improvement (QAPI) Committee meeting and take further action as necessary.	

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care plan meeting with him since his admission.

In an interview with Admission Director on 5/22/2024 at 8:31 a.m., she stated she was unable to locate documentation that a care plan meeting was held for Resident #86 after his admission. She said Admission Director or the Social Worker (who was no longer employed at the facility) scheduled the 72-hour care plan meetings for newly admitted residents and recorded scheduled care plan meetings on a calendar. The Admission Director was unable to provide documentation when a care plan meeting was scheduled for Resident #86.

In an interview with the Administrator (who was in the Admission Director's office) on 5/22/2024 at 8:31 a.m., she stated Resident #86 should have received a 72-hour care plan meeting after his admission to the facility. She explained there was no documentation of care plan meetings in residents' electronic medical record (EMR) because there was no one assigned to document care plan meetings into resident EMR.

Nursing documentation dated 5/21/2024 at 2:15 p.m. by the MDS Nurse recorded a 72-hour care plan meeting was attempted, and the facility was unsuccessful in reaching Resident #86's contact person.

In an interview with the MDS Nurse on 5/22/2024 at 9:38 a.m., she explained there was no 72-hour care plan meeting conducted for Resident #86 after his admission. She stated a 72-hour care plan meeting was held on 5/21/2024 and she attempted to contact Resident #86's contact person. She explained she signed the baseline care plan on 5/21/2024 as documentation a care

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plan meeting was held. She said the Admission Director was responsible for setting up the initial 72-hour care plan meeting.

2. Resident #38 was admitted to the facility on 1/13/2024 with diagnoses including stroke.

There were no signatures for Resident #38, Resident #38's Representative or staff recorded on Resident #38's baseline care plan dated 1/13/2024. The baseline care plan indicated Resident #38 understood and communicates with staff easily.

Resident #38's comprehensive care plan was updated on 3/15/2024 that reflected Resident #38 had a terminal prognosis.

The significant change Minimum Data Set (MDS) assessment dated 3/25/2024 indicated Resident #38 was moderately cognitively impaired.

There was no documentation in Resident #38's electronic medical record (EMR) that a care plan meeting had been held following admission to the facility for Resident #38.

In an interview with Resident #38 on 5/19/2024 at 10:58 a.m., she stated the facility had not conducted a care plan meeting with her to discuss her care, and she was not aware of the facility having a care plan meeting with Resident #38's Representative.

An attempt on 5/22/2024 to reach Resident #38's Representative was unsuccessful.

In an interview with Admission Director/Social Worker on 5/21/2024 at 2:11 p.m., she stated

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since March 2024 she had been responsible for scheduling the 72-hour care plan meetings after admission and thought a care plan meeting was held for Resident #38.

In a follow up interview with Admission Director on 5/22/2024 at 8:31a.m., she stated she was unable to locate any documentation that a 72-hour care plan meeting was held for Resident #38.

In an interview with the Administrator on 5/22/2024 at 8:31 a.m., she explained 72-hour care plan meeting should be held with new admissions at the facility. She explained there was no documentation of a care plan meeting for Resident #38 because there was no one assigned the responsibility to document a care plan meeting was held into residents' EMR.

3. Resident #26 was admitted to the facility on 8/8/17 with diagnosis including stroke.

Resident #26's electronic medical record revealed the last documented care plan meeting occurred on 2/1/21.

Minimum Data Set (MDS) assessments were completed for Resident #26 on the following dates: 4/25/23 (annual), 7/26/23 (quarterly), 10/26/23 (quarterly), and 1/26/24 (quarterly).

The annual MDS assessment dated 3/1/24 revealed Resident #26 was cognitively intact.

In an interview with Resident #26 on 5/19/24 at 11:51 am, he stated he had not attended or been

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LAUREL PARK REHABILITATION AND HEALTHCARE CENTER	901 HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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F 657	Continued From page 12 invited to a care plan meeting since 2021. During an interview with the MDS Coordinator on 5/21/24 at 2:57 pm, she stated the Social Worker, who left the facility in March 2024, was responsible for creating and maintaining the care plan meeting calendar, sending out care plan meeting invitations, and holding care plan meetings quarterly. In an interview with the Administrator on 5/21/24 at 3:20 pm, she stated the previous Social Worker was responsible for scheduling the care plan meetings. She further stated when she started her position as administrator at the facility, she was unaware the care plan meeting had not been done. She further revealed the Admissions Director was working on scheduling care plan meetings that needed to be completed.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to obtain a physician order on a resident's medical record for the use of supplemental oxygen and apply signage indicating the use of oxygen outside the resident's	F 695	Resident #292 a physician order for oxygen was obtained on date 6/4/24. Oxygen signage was placed on the door of the resident room on date 6/4/24. 2. All Residents who have an physician	6/19/24

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F 695	Continued From page 13 room for 1 of 2 residents reviewed for oxygen use (Resident #292). Findings included: Resident #292 was admitted to the facility on 5/2/2024 with diagnoses including chronic heart failure and chronic respiratory failure. Discharge orders dated 5/2/2024 included the use of supplemental oxygen to maintain oxygen saturation greater than or equal to 90%. Nursing documentation dated 5/2/2024 recorded Resident #292 on arrival to the facility at 4:40p.m. was receiving oxygen at 2 liters per minute vis nasal cannula. The 5-day admission Minimum Data Set (MDS) assessment dated 5/8/2024 indicated Resident #292 was cognitively intact and the use of oxygen. Further nursing documentation dated 5/8/2024 recorded Resident #292's oxygen saturation decreased to 80%. The physician was notified and Resident #292's oxygen was increased to 3 liters per minute to maintain an oxygen saturation of 96%. A physician progress note dated 5/9/2024 at 8:27 a.m. recorded Resident #292's oxygen saturation was 80% overnight and was placed on 3 liters per minute of oxygen with oxygen saturation increasing to 96%. The physician's note further recorded oxygen was ordered as needed to maintain oxygen saturation above 90%. The care plan dated 5/16/2024 indicated	F 695	order for oxygen have the potential to be affected by the deficiency. An Audits were conducted on 5/27/24 by the DON and ADON to ensure residents that require oxygen have a physician order and signage on the residents door. 3. The DON or designee has educated the licensed staff that when a resident requires oxygen therapy a physician order will be obtained and signage will be placed on the residents door on 6/13/24. In addition, new hire licensed nursing staff will be educated in orientation to ensure that residents with oxygen needs will have an physician order and proper signage. 4. The DON will audit three residents that require oxygen therapy weekly for two weeks and then monthly for 3 months that residents that require oxygen therapy have a physician order documented in the medical record and have signage outside the residents door; these results of the oxygen audits will be reviewed monthly for three months during the Quality Assurance Performance Improvement (QAPI) Committee meeting and take further action as necessary.	

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F 695	Continued From page 14	F 695		

Resident #292's was using oxygen therapy due to congestive heart failure, ineffective gas exchange and respiratory illness. Interventions included giving medications as ordered by the physician.

There was no physician order for the use of oxygen therapy in Resident #292's medical record.

On 5/19/2024 at 12:07 p.m., there was no signage outside Resident #292's room indicating the use of oxygen. Resident #292 was observed wearing oxygen via nasal cannula at 3.5 liters per minute.

On 5/21/2024 at 3:26 p.m. in an interview with Nurse #3, she explained Resident #292 used oxygen continuously and she did not recognize on 5/19/2024 (as nurse assigned to Resident #292) there was no "Oxygen in use, no smoking" signage outside his door. She stated an "Oxygen in use, no smoking" sign should have been placed outside Resident #292's door when he was admitted or when nursing staff recognized signage was not outside the door. After reviewing Resident #292's orders, Nurse #3 stated there was no order for the use of 3.5 liters per minute of oxygen for Resident #292 in the physician's orders. She explained the nursing staff could administer up to 2 liters per minute of oxygen when residents were in distress but usually called the physician for an order when oxygen was needed. She explained any nurse could enter a physician order for the use of oxygen and stated she did not know why there was not an order in Resident #262's electronic medial record (EMR) for the use of oxygen.

On 5/22/2024 at 11:04 a.m. in an interview with

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F 695	Continued From page 15 the Director of Nursing, she stated oxygen orders came with discharge orders for Resident #292 and an order for the use of oxygen should have been entered by the nursing staff into the EMR for Resident #292. She further stated when physician was called and supplemental oxygen was increase, the nursing staff should had entered an order into Resident #292's EMR. She explained the nursing staff was responsible to ensure an "Oxygen in use, no smoking" sign was outside Resident #292's door due to oxygen in use.	F 695		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide all food in bowls as ordered by the physician for 1 of 1 residents requiring adaptive equipment for meals (Resident #36). Findings included: Resident #36 was readmitted to the facility on 12/15/23. A physician order dated 2/27/24 for Resident #36 revealed that all food was to be placed in individual bowls at all meals to increase with self-feeding secondary to decreased vision.	F 810	Resident #36 was identified and corrected on date 5/24/24 to have food in bowls as ordered by the physician. 2. All residents with adaptive equipment with eating have the potential to be affected by this deficiency. An audit was completed on 6/13/2024 by Director of Rehab to ensure all residents with adaptive equipment with eating was in place. 3. The administrator has educated the dietary staff on 6/14/2024 to ensure adaptive equipment in in place as ordered by the physician. In addition, new	6/19/24

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F 810	Continued From page 16 The Minimum Data Set (MDS) Annual Assessment dated 4/12/24 revealed Resident #36 was cognitively intact, had highly impaired vision, and required setup help for eating. An observation on 5/20/24 at 12:24 PM revealed Resident #36 was observed to have the lunch meal served on a flat plate in her room. The meal ticket stated all food was to be served in bowls. Only the dessert item was placed in a bowl. Resident #36 stated that her lunch meal should have been served in bowls. A new meal placed in bowls was offered to Resident #36, but she declined. An observation and interview with the Director of Rehab took place on 5/20/24 at 12:30 PM, and he confirmed that Resident #36's lunch meal was served on a flat plate. The Director of Rehab stated that he had ordered all food for all meals to be served in bowls, so that Resident #36 had an easier time eating due to blindness in both eyes. He further stated that the food should have been served in separate bowls because Resident #36 could not see the food items. The Director of Rehab indicated that he notified the previous Dietary Manager (DM) back in February 2024 about the new order for adaptive equipment. He stated he was going to go to the kitchen and notify the current DM that Resident #36's lunch was not served in bowls. The DM was interviewed on 5/20/24 at 2:55 PM. He stated he began at the facility in early March 2024. The DM indicated that he was aware of the order to provide food in bowls at all meals for Resident #36. He stated the Director of Rehab notified him that her lunch meal was not served in	F 810	hire dietary staff will be educated in orientation to ensure that residents that have adaptive equipment recommendations are provided with the appropriate devices. 4. The Dietary Manager will audit five residents that have adaptive equipment with eating is in place as ordered by the physician weekly for two weeks and then monthly for three months; these results will be reviewed during the Quality Assurance Performance Improvement (QAPI) Committee meeting and take further action as necessary.	

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F 810	Continued From page 17	F 810		

bowls. The DM revealed that he went to Resident #36's room to offer a new meal in bowls, and she declined. The original order was for a divided plate, but therapy requested bowls because she was able to handle the food better. The DM stated this had not been an issue before, and Resident #36 never previously complained to him about not receiving food in bowls at meals.

On 5/21/24 at 10:03 AM, Nurse Aide (NA) #1 was interviewed. She revealed that Resident #36's food was usually served in bowls, and if not, she would notify the kitchen. NA #1 stated that this has happened once or twice previously. She confirmed that she saw Resident #36's lunch meal was not served in bowls, but the Director of Rehab went to the kitchen to notify the staff before she could.

During an interview with the MDS Nurse on 5/21/24 at 1:28 PM, she revealed that nursing staff should have double checked Resident #36's lunch meal before it was served to her. The MDS Nurse indicated that Resident #36 should have received food in bowls to make eating easier for her due to highly impaired vision.

An interview was conducted with the Director of Nursing (DON) on 5/21/24 at 1:36 PM. She revealed that someone in the kitchen should have provided the correct adaptive equipment for Resident #36's lunch meal. If the meal was not served in bowls as ordered, the nursing staff should have looked at the meal ticket and if it was not correct, they should have corrected immediately with kitchen assistance.

The Administrator was interviewed on 5/21/24 at 1:56 PM. She revealed that that the plan of care

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F 810	Continued From page 18 should have been followed, and Resident #36's lunch meal should have been provided in bowls.	F 810		
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 observations, and staff interviews the facility failed to maintain 2 of 4 skillets and 9 of 15 baking sheets free from grease build up and failed to maintain one ice scoop holder free of standing water and mold. These practices had the potential to affect ice and food served to residents. The facility census was 91 residents. Findings included: 1. An observation of the kitchen dishware on 5/19/24 at 10:20 AM revealed:	F 812	1. Skillets and baking sheets were cleaned/ replaced. Ice scoop was cleaned on date 6/12/2024 by Dietary Manager. 2. All residents have the ability to be affected by this deficiency. An audit was completed by Dietary Manager on 6/12/2024 to ensure all skillets and baking sheets are free from grease and ice scoops holders are free from standing water and	6/19/24

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F 812	Continued From page 19 - 2 skillets hung up, ready for use with grease build up on the bottom of the skillets - 3 baking sheets with dark grease built up under the rims were observed stacked on the drying rack ready for use A second observation of the kitchen dishware on 5/21/24 at 9:33 AM revealed: - 2 skillets hung up, ready for use with grease build up on the bottom of the skillets - 3 baking sheets with dark grease built up under the rims were observed stacked on the drying rack ready for use A third observation of the kitchen dishware on 5/22/24 at 9:57 AM revealed: - 2 skillets hung up, ready for use with grease build up on the bottom of the skillets - 9 baking sheets with dark grease built up under the rims were observed stacked on the drying rack ready for use In an interview on 5/22/24 at 10:21 AM the Administrator indicated if staff could not clean the baking sheets and fry pans then they would purchase new ones. 2. An observation on 5/21/24 at 9:43 AM of the hall ice machine revealed the ice scoop holder with a film of pink water and mold on the bottom of the ice scoop holder. In an interview on 5/21/24 at 9:58 AM the Certified Dietary Manager (CDM) indicated staff on the hall were responsible for the hall ice machine and scoop holder, but he would clean it immediately.	F 812	mold. 3. The administrator has educated the dietary staff on 6/14/2024 to ensure skillets and baking sheets are grease free and ice scoop holders are free from standing water and mold. 4. The administrator or Designee will audit the kitchen weekly for two weeks and monthly for three months that baking sheets and skillets are free of grease and ice scoops are free of standing water and mold; these results will be reviewed during the Quality Assurance Performance Improvement (QAPI) Committee meeting and take further action as necessary.	

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F 812	Continued From page 20 In an interview on 5/22/24 at 10:21 AM the Administrator indicated that all staff were responsible for the ice machine and ice scoop holder. She indicated staff should see if the ice scoop holder was removable and washed on a daily basis.	F 812		