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	345227	A. BUILDING ______ B. WING ______	C 06/20/2024

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CYPRESS VALLEY CNTR FOR NURSING AND REHABILITATION	**543 MAPLE AVENUE REIDSVILLE, NC 27320**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 6/17/2024 - 6/20/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #4WE911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 6/17/2024 through 6/20/2024. Event ID# 4WE911. The following intakes were investigated NC00209212, NC00209334, NC00211282, NC00211635, NC00212433, NC00213044, NC00215822, NC00218014, NC00218162. 4 of the 27 complaint allegations resulted in deficiencies.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		7/18/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/16/2024

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 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview and record review, the facility failed to clean and maintain resident rooms for 3 of 3 halls (Rooms A11, A15, A17, A19, A20, A21, A22, A25, B16, C12, C26) observed for cleanliness. The findings included: An initial tour observation was conducted on 6/17/24 at 10:00 AM-10:30 AM revealed several resident rooms and were observed on 3 of 3 halls the floors were sticky when walking across the floor, there was left over food, old paper cups, wrappers, straws, dingy, dirty brown matter, and stains in the floors. The corners and base boards	F 584	Cypress Valley Center acknowledges receipt of deficiencies and proposes this plan of correction to the extent that the summary of findings. This plan of correction is submitted as a written allegation of compliance. All residents have the potential to be affected by the deficient practice: 1.Rooms A11, A15, A17, A19, A20, A21, A22, A25, B16, C12, C26 and Hallways were cleaned immediately after findings by the Environmental Service Director and Housekeeping aides; in addition, the base	

F 584

Continued From page 2
of the rooms were embedded with dried food products, encrusted dirt and needed to be repaired.

1a. An observation was conducted on 6/17/24 at 10:00 AM, Room A11, the floors underneath nightstand was very sticky, with brown matter, old food/paper products on the floor.

b. An observation was conducted on 6/17/24 at 10:05 AM, Room A15, the floor was stained and dirty, sticky, with old paper products and food under the nightstand and beside the closet.

c. An observation was conducted on 6/17/24 at 10:07 AM, Room A17 a hole was in the baseboard of room near bed B, the baseboard was detached from the wall with broken and exposed sheet rock. The floor was dirty sticky, leftover cups, paper products and old food underneath, the nightstands.

d. An observation was conducted on 6/17/24 at 10:09 AM, Room A19 the floor was sticky when walked across, underneath the bed and nightstand, there was a hole in the wall and baseboard coming apart from the wall.

e. An observation was conducted on 6/17/24 at 10:10AM, Room 20 the floor was very sticky, underneath the nightstand and bed there was left over food and paper products on floor.

f. An observation was conducted on 6/17/24 at 10:12AM, Room A21 the floor was dirty, sticky and paper products were behind and underneath the nightstand.

g. An observation was conducted on 6/17/24 at

F 584

boards in the rooms were wiped down and the work orders were placed in the TEL□s system for the Maintenance Departments to make all necessary repairs.

2.To identify other resident□s rooms having the potential to be affected by the same deficient practice:

The Environmental Service Director and Maintenance Director inspected all resident□s rooms for cleanliness and needed repairs.

3.The measures that were put in place to ensure that deficient practice will not recur:

More housekeeping aides were hired with the start date of 6/28/2024 and the facility is continuing to interview and hire more housekeeping staff.

All staff were provided with education on Residents□ rights to a safe, clean, comfortable homelike environment; including all trash being removed daily, old food discarded daily from resident□s room. The Maintenance Director was trained in the TEL□s system where work orders are placed to ensure repairs.

All potential new hires will be educated in orientation to resident□s rights to a safe, clean, comfortable environment and reporting repairs needed within 48hours. Environmental Service Director created a daily, weekly, and Monthly task sheet and a deep clean task sheet. All housekeeping

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F 584	Continued From page 3 10:14 AM, Room A22 floors dirty sticky, paper products behind nightstand,. h. An observation was conducted on 6/17/24 at 10:16 AM, Room A25 the floor was stained with brown matter, baseboard behind bed coming apart from the wall and the sheet rock was exposed. i. An observation was conducted on 6/17/24 at 10:16 AM, Room A29 the floor was dirty, sticky and stained with brown matter around baseboards, under nightstand and closet area. j. An observation was conducted on 6/17/24 at 10:18 AM, Room B16, underneath nightstand and under bed had leftover food and paper products. The floor was very dirty and sticky when walked across. k. An observation was conducted on 6/17/24 at 10:20 AM, Room B24 there was a hole in wall behind bed, leftover paper products and food was underneath nightstand and closet area. l. An observation was conducted on 6/17/24 at 10:21AM, Tomm C12 underneath the nightstand and around the closet area leftover food and paper products was on the floor. The floor was sticky, heavily stained with brown matter and dried liquids. m. An observation was conducted on 6/17/24 at 10:27 AM, Room C26, the baseboard coming apart from the wall and particles of sheet rock broken left on floor. An interview was conducted on 6/19/24 at 8:30 AM, the Housekeeper #1 stated due to staffing	F 584	and laundry staff were educated on July 9th 2024 to the cleaning task sheets to be used. 4.The Facility plans to monitor its performance to make sure the solution is sustained: The Environmental service Director will Monitor the housekeeping daily, weekly, monthly tasks upon completion and sign off for completion employee task for weekly x□s 2 months then weekly x□s 1 month. Department heads will be assigned daily room rounds to monitor the cleanliness of rooms and report any repairs needed to Maintenance Director via work orders in the daily stand down meeting weekly x□s 4 weeks then weekly x□s two months. Completions for repairs will be tracked in the TEL□s system by the Maintenance Director and reviewed weekly by the Administrator for 2 months to ensure that all work orders are entered and completed timely. 5.The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of this plan monthly for twelve months and will make additional interventions and or recommendations if needed to ensure continues compliance. The person responsible for the implementation and compliance of this plan of correction will be the	

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F 584	Continued From page 4 shortage she tries to complete as many rooms on her assignment as possible. She reported she was responsible for overall cleaning of the room, bathrooms, common areas, shower rooms, behind resident furniture, however, due to limited staff she cleans most critical areas and would get behind nightstands and in between closet, under beds when time allowed. She reported most of the time deep cleaning would include cleaning behind and under nightstands. An interview was conducted on 6/19/24 at 9:55, the Housekeeper #2 stated there were times when there were only two housekeepers, and she was unable to complete all the assigned rooms due to some rooms needed more attention than others. She reported that when her co-worker calls out the assignment increases, and she tries to do her best to clean as many rooms as possible. She further stated she may not be able to complete all the designated assignments on the daily checklist and/or deep cleaning list. She reported when there are 3 housekeepers scheduled it would normally be a deep cleaning day which throws the assignments off and if one-person doesn't show the assignment increase and we all try to clean the most critical areas. She reported she was responsible for cleaning under beds, under and behind nightstands/closets, however, time may not allow for the deep cleaning process. An observation and interview were conducted on 6/19/24 at 10:30 AM of the condition of resident rooms with the Maintenance Director who stated he started the position on 6/17/24. He stated he was not aware of all the environmental needs of the facility and planned to discuss any of the observations and concerns with the administrator	F 584	Administrator. Compliance date: July 18, 2024	

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F 584	Continued From page 5	F 584		

and housekeeping supervisor. He was unaware of the current system in place to ensure repairs were completed.

An interview was conducted on 6/19/24 at 10:50 AM, the Housekeeping Director who stated she was responsible for ensuring the housekeeping staff were maintaining the cleanliness of the environment. However, due to staffing issues she did not have the opportunity to follow up and observe whether the housekeeping staff were keeping up the cleaning schedules. She further stated two new housekeepers were hired and she would be stepping down from the role of the director. She further stated on a typical day there maybe 2 housekeepers 1 floor tech and 1 laundry staff most days. When there was a call out, she may have to step into the role of housekeeper, therefore she would be unable to follow-up behind the staff.

An interview was conducted on 6/19/24 at 11:00 AM, the Floor Tech stated she worked 5AM-1PM and her responsibility was to empty trash, check and change curtains, buff/mop floors. She stated the second shift tech works 1PM-8:30 PM, she further stated housekeeping department has been short of staff for a while and they may not get to all resident rooms to deep clean, on a regular basis. She reported she tries to do as many rooms assigned on the schedule to the best of her ability. She reported if she was the only one working as a floor tech, she may not get to all the assigned rooms.

An interview was conducted on 6/19/24 at 11:43 AM, the Administrator who stated the facility Environmental Service Director and Maintenance Director was responsible for ensuring the facility

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F 584	Continued From page 6 was clean and structural repairs were completed for the safety of all the residents. She stated resident room audits would be done based on the recent facility assessment. She indicated the Maintenance Director and additional housekeeping staff were recently hired on 6/17/24.	F 584		
F 641 SS=B	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 staff interviews, and record review the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of cognitive patterns, and medication for 2 of 2 residents reviewed for resident assessment (Resident #251 and Resident #38). Findings included: 1. Resident #251 was admitted to the facility on 4/3/23 with diagnoses that included malignant neoplasm and tracheostomy status. Review of the Quarterly Minimum Data Set (MDS) assessment dated 10/3/23 indicated Resident #251 had adequate hearing, no speech, and was usually understood. The Cognitive Patters section was not assessed and marked as "the resident is rarely/never understood." The Staff Assessment for Mental Status was also marked as "not assessed." During an interview on 6/19/24 at 11:55 AM, the	F 641	Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #251 MDS was corrected on 7/11/2024 for MDS assessment dated 10/03/2023 and Resident #38 MDS was corrected on 6/19/2024 for MDS assessment dated 4/24/2024. 2.All residents have the potential to be affected by the same deficient practice. On 6/20/2024 the Interdisciplinary team audited the most recent MDS assessments cognitive section C0700, C1000, and N0350 A for all current residents with clinical review during the look-back period to ensure accuracy. No issues with MDS accuracy were noted during facility audit of sections C0700, C1000, and N0350 A. 3.The measures that were put in place to	7/18/24

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F 641 Continued From page 7

MDS nurse indicated if any resident was unable to be interviewed for the cognition section, then the staff should be interviewed about the resident's cognitive status. She stated the cognition section should have been completed using staff interview and the resident's cognition status assessed appropriately. The MDS nurse indicated the cognition section should be completed for all residents.

During an interview with the Administrator on 6/20/24 at 5:27 PM, she indicated it was her expectation that all MDS assessments were completed accurately. The MDS assessments should correctly reflect the resident's cognition status.

2. Resident #38 was admitted to the facility on 4/18/2024.

A review of the medication orders for Resident #38 did not reveal she had been prescribed insulin injections.

A review of the admission MDS assessment dated 4/24/24 indicated Resident #38 received an insulin injection on 1 of the 7 days during the look back period.

During an interview on 6/19/24 at 11:55 AM, the MDS nurse stated Resident #38 received a Tuberculosis (TB) test (skin injection) upon admission. She indicated it had been an error to mark it as an insulin injection.

During an interview with the Administrator on 6/20/24 at 5:27 PM, she indicated it was her expectation that all MDS assessments were completed accurately. The MDS assessments

F 641

ensure that the deficient practice will not recur:

06/25/2024 the MDS coordinators completed in-service education for Nursing interdisciplinary Team that are responsible for completing MDS assessments to include review of RAI manual with emphasis on MDS accuracy of assessments. This information will be included in the employee orientation program for newly hired IDT members who will complete MDS Assessments.

Prior to closing of MDS assessments the MDS coordinators will validate accuracy of sections C0700, C1000, and N0350A with clinical record review during the look-back period to ensure accuracy for 100% of assessments completed weekly x□s 4 weeks, then 50%weekly x□s 4 weeks and then 25% weekly x 4 weeks.

4.The facility plans to monitor its performance to make sure that solutions are sustained:

5.The MDS coordinators will reporting findings of MDS validation audit of sections C0700, C1000, and N0350A to the Quality Assurance Performance Improvement Committee Monthly x□s 3 months to ensure compliance is sustained.

The person responsible for the implementation and compliance of this plan of correction will be the Administrator.

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F 641	Continued From page 8 should correctly reflect the medications administered to the residents.	F 641	Compliance date: July 18, 2024	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 660		7/18/24

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F 660	Continued From page 9 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's	F 660		

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F 660	Continued From page 10 discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interviews, the facility failed to implement an effective discharge planning process for 1 of 1 resident reviewed for discharge to the community (Resident #100). The findings included: Resident #100 was admitted to the facility on 4/3/24 with diagnoses that included right femur fracture, peripheral vascular disease, atrial fibrillation and chronic pulmonary obstruction disease. Resident #100's admission Minimum Data Set (MDS) assessment dated 4/8/24 coded Resident #100's cognition was intact. The resident needed one-person assistance with activities of daily living. Review of the discharge plan section of the admission MDS dated 4/8/24 asked the question whether active discharge planning already occurred for the resident to return to the community and the answer was no. There was no admission assessment completed. Care area assessment (CAA) from the admission MDS dated 4/8/24 did not trigger for discharge to the community. Review of the care plan dated 4/6/24 revealed there was no documentation for Resident #100's discharge plan to return to the community.	F 660	1.The corrective action that was taken for residents found to have been affected by the deficient practices: On 4/18/2024 resident # 100 signed Notice of Medicare Non-Coverage by the facility which Skilled Nursing facility services ended on 4/20/2024. On 6/20/2024 Nurse did a late entry for resident #100 discharge summary, resident #100 daughter pick resident up on 4/21/2024 Med list with orders and H & P. Medications were reviewed with resident # 100 daughter and informed to follow up with resident□s PCP. D/C orders for PT and OT was completed on 4/22/2024 and Center Well Home health was called with referral from Cypress for resident #100 to be picked up. Center Well went out to resident #100 home on 4/25/24 to provide home health services with PT start of Care on 4/28/2024 and OT Eval visit on 5/8/2024. Resident #100 was provided Therapy Services by Center Well until goals were met for PT discharge visit 5/21 and OT discharged visit on 5/28/2024. 2.All residents have the potential to be	

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F 660	Continued From page 11 Review of the notice of Medicare Non-Coverage revealed the service would end on 4/20/24. The notice was signed by Resident #100 on 4/18/24. A telephone interview was conducted on 6/20/24 at 5:34 PM and the family member stated she had been informed by the insurance company of the pending discharge date as 4/21/24. She further stated the facility did not discuss or schedule a discharge planning meeting at the time of admission or prior to discharge. She was unaware of the discharge process and was called on 4/19/24 by the facility to sign a discharge notice form. She could not recall who called her. The family member explained when she arrived on 4/21/24, the nursing staff on duty acted as though they were unaware Resident #100 would be discharged. She further stated there was no information provided at the time of discharge to include home health services, prescriptions for medication or instruction for home care. She further stated the nurse on duty told her she needed to call back on the morning of (4/22/24) for further instruction. She reported when she called back on 4/22/24, she returned to the facility to get Resident #100's prescriptions and was given a name and number to contact for a home health program. Resident #100 did not receive home health or therapy services for 3 weeks. The family stated she contacted the home health service to make the arrangements. An interview was conducted on 6/20/24 at 6:00 PM with Nurse #9 who stated she worked on 6/21/24 and she was unaware Resident #100 was being discharged until the family arrived for pick-up. Nurse #9 reported the discharge paperwork had not been prepared or available for the discharge. She stated she was only able to	F 660	affected by the same deficient practice: The Unit Managers conducted an audit on all discharged residents from the remaining month of April 21, 2024, through April 30, 2024, on July 11, 24 to ensure that resident□s discharge planning was in place. No other residents were affected. 3.The measures that were put in place or systematic changes made to ensure that the deficient practice will not recur: On 7/9/2024 SDC provided education to the clinical disciplinary team on completing discharge planning for short-term and long-term residents and documenting in the electronic medical record. Any new hired MDS staff, Nurse and Social Service Director will receive education on discharge planning during orientation. The facility is currently interviewing for Social Service Director with experience in long-term Care. The Unit Managers and MDS Nurses will complete a discharge planning assessment upon admissions for residents to ensure proper planning for return to community. 4.The facility plans to monitor its performance to make sure that solutions are sustained: The Administrator will audit admissions to	

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F 660	Continued From page 12 provide the family with a medication list and a previously done history and physical assessment done by the nurse practitioner. She instructed the family to contact the facility in the morning for prescription orders and home health services. She stated the discharge process would have included an interdisciplinary meeting and all orders and services would be complied with a packet prepared by the social worker prior to discharge to be reviewed with the resident and family. Nurse #9 reported she was only able to provide what was available in the record. An interview was conducted on 6/19/20/24 at 10:45 AM with the Nurse Practitioner (NP) who stated Resident #100 was only in the facility for 18 days for rehab services. He stated there was no significant concerns or incident other than her rehab recovery. The Nurse Practitioner stated he did not do a discharge summary at the time of discharge. The nursing staff and social worker would prepare the paperwork and discuss resident community plans and services. He stated he saw the resident on 4/8/24, with knowledge the resident would return home at the completion of therapy. He stated the resident expressed a desire to return home during the assessment. He was unaware of the events of the discharge plan after that point Review of the physical therapy discharge summary dated 4/23/24 documented Resident #100 was seen by physical therapy for lower extremity therapeutic exercise for strength and balance with cues for techniques. The facility improved her standing balance reactions, ambulation with rolling walker in room with good progress. Resident #100 left the facility against medical advice.	F 660	ensure discharge plans are in place weekly x 12 weeks. Results of these audits will be reviewed by the Quality Assurance Improvement Committee monthly x s 3 to ensure continues compliance. The person responsible for the implementation and compliance of this plan of correction will be the Administrator. Completion Date: July 18, 2024	

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An interview was conducted on 6/20/24 at 3:52 PM, the Rehab Director stated Resident #100 was seen 4/4/24-4/19/24. She was admitted for rehab due to hip fracture. She stated the resident was independent with activities of daily living at the time of discharge and only needed lower body assistance but would need physical therapy in the home. She further stated a formal discharge meeting regarding the resident's progress or discharge plans for home care did not happen. She did not state why the meeting did not occur. The resident had discharged on the weekend. The Rehab Director did not respond to why the resident was listed as against medical advice

An interview was conducted on 6/20/24 at 5:10 PM in conjunction with a record review with the Director of Nursing and revealed a discharge planning meeting with the resident, family and the interdisciplinary team had not taken place. The Director of Nursing acknowledged the facility did not implement the discharge process on admission and at the time of discharge.

An interview on 6/20/24 at 4:43 PM in conjunction with a record review with the Admission staff revealed the discharge plan was not done on admission and at the time of discharge. She acknowledged the discharge plan was missed due to the absence of a social worker.

An interview on 6/20/24 at 4:43 PM in conjunction with a record review with the Administrator revealed all residents should have a discharge planning meeting on admission and prior to discharge with the resident and family. The interdisciplinary team was expected to meet prior to a scheduled discharge to discuss and prepare

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F 660	Continued From page 14 a packet of information of all the resident's orders with prescription medications and ensure the resident's home care needs were in place prior to the discharge. The record revealed there was no referral made to home health services prior to discharge to reflect Resident #100's healthcare needs at the time of discharge. The social worker would prepare the packet for the nursing staff prior to discharge. The discharging nurse would review the information with the resident and responsible person to ensure all services and instructions were in place at the time of discharge. The Administrator acknowledged due to the absence of a social worker the discharge process was not implemented in accordance with the facility policy. Moving forward, an audit of all discharges would be implemented immediately. The Administrator did not respond to why the resident was listed as against medical advice.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge	F 661		7/18/24

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F 661	Continued From page 15 medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a recapitulation of stay for 1 of 1 closed record reviewed for discharge to the community(Resident #100). The findings included: Resident #100 was admitted to the facility on 4/3/24 with diagnoses that included right femur fracture, peripheral vascular disease, atrial fibrillation and chronic pulmonary obstruction disease. Resident #100 admission Minimum Data Set(MDS) assessment dated 4/ 8 /24 coded Resident #100's cognition was intact. Resident #100 was discharged home on 4/21/24 and review of the record revealed the facility did not complete a recapitulation of stay. An interview on 6/20/24 at 4:43 PM, the Administrator stated a recapitulation of the stay would be completed by the interdisciplinary team to capture the full extent of the services provided	F 661	1.The corrective action that was taken for residents found to have been affected by the deficient practice: On 7/11/2024 the Unit manager completed a late entry recapitulation of stay on resident # 100 to ensure that it was in place. 2.All residents have the potential to be affected by the same deficient practice. The Unit Managers conducted an audit on five residents that were discharged on April 21, 2024 through April 30, 2024 on 7/11/24 to ensure that the discharge summary included recapitulation of resident stay was completed No other residents were affected. 3.The measures that were put in place or systematic changes made to ensure that the deficient practice will not recur: SDC provided education to the clinical	

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F 661	Continued From page 16 to the resident during their stay. The Administrator acknowledged due to the absence of a social worker the discharge summary was not completed. She further stated nursing and social worker was responsible for ensuring the completion of the discharge summary. Moving forward, an audit of all discharges would be implemented immediately. An interview was conducted on 6/20/24 at 5:10 PM, in conjunction with a record review with the Director of Nursing revealed the discharge summary had not been completed. The Director of Nursing stated she was unsure why the facility had not completed the recapitulation of the resident's stay.	F 661	Interdisciplinary team on completing a discharge summary to include a recapitulation of stay for short-term and long-term residents. All newly hired Nurses, MDS staff and Social Services staff will receive education during orientation on completing a discharge summary to include recapitulation of stay in the discharge summary on all anticipated discharges. The Floor nurses, MDS Nurses, and Unit Managers will complete the discharge summary to include the recapitulation of residents stay. 4.The facility plans to monitor its performance to make sure that solutions are sustained: The Nursing interdisciplinary team will conduct a weekly audit of all discharge summaries for residents with anticipated discharges utilizing the discharge Summary audit tools weekly for 4 weeks then biweekly for two weeks. Any identified concerns will be addressed immediately by the Nursing Interdisciplinary team. The DON will review and sign Discharge Summary Audit tool weekly for 4 weeks, then bi-weekly for two weeks to ensure continues compliance. Results of these audits will be reviewed by the Quality Assurance Improvement Committee monthly x□s 2 to ensure	

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F 661	Continued From page 17	F 661	continues compliance. The person responsible for the implementation and compliance of this plan of correction will be the Administrator. Compliance Date: July 18, 2024	
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage on 14 of 123 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 2, 2024 (January 1-March 31, 2024) revealed the facility had no Registered Nurse (RN) coverage	F 727	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility failed to ensure RN coverage for at least 8 consecutive hours a day for 8 out of 30 days. 2.All residents have the potential to be affected by the same deficient practice:	7/18/24

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on 03/02/24, 03/09/24, 03/10/24, 03/24/24, 03/30/24, 03/31/24.

Review of the daily assignment schedules from May 17, 2024, through June 17, 2024, revealed the facility failed to provide 8 hours of RN coverage on the following dates: 06/1/24, 06/9/24, 06/12/24, 06/13/24, 06/14/24, 06/15/24, 06/16/24, 06/17/24.

During an interview with the Director of Nursing (DON) on 06/20/24 at 12:03 pm it was indicated staffing schedules were done by the Scheduler. She indicated when she first started working in the facility the facility had utilized agency staff, and as they were phasing out agency it was noticed they were having issues with RN coverage.

On 06/20/24 at 4:38 pm an interview was conducted with the Scheduler, and she indicated she was aware of the requirement to have 8-hour RN coverage. She stated she tried to schedule RNs for 8 hours and the days that had no RN coverage a RN had been scheduled but they called out.

An interview was conducted on 06/20/24 at 3:00 pm with the Administrator and she indicated it was her expectation that a RN would be in the facility 8 hours consecutively daily. She stated she was not made aware of the call outs from the Scheduler, and that she had informed her going forward that she needed to be informed if there was a RN coverage problem.

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RN coverage was reviewed for the rest of the schedule with the scheduler by the DON to ensure there was at least 8 consecutive hours a day for 7 days a week for the rest of the Month of June 2024. No deficient practice found

3.The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:

The Administrator conducted an audit on all schedules from June 18, 2024, through June 30, 2024, to ensure the 8 hours of RN coverage.

All RN Nurses and the staffing Coordinator were in-serviced by the SDC that there must be 8 consecutive hours a day for 7 days a week of Registered Nurse coverage and to ensure that they remain on the clock for the full 8 hours.

4.The facility plans to monitor its performance to make sure that solutions are sustained:

The DON and Scheduler will monitor the daily schedule and time clock punches Monday through Sunday to ensure that there are consecutive hours for 7 days a week of RN Coverage for 8 hours.

If any RN calls-out the Scheduler must notify the DON immediately so that RN coverage is found for that day.

This will be an ongoing audit and all

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F 727	Continued From page 19	F 727	results of audit will be reviewed weekly in Standup and Stand down x□s 4 weeks then monthly for 3 months to ensure continues compliance. The person responsible for the implementation and compliance of this plan of correction will be the DON. Compliance Date: July 18, 2024	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		7/18/24

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This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews, the facility failed to date opened multi-dose insulin pen injections in 2 of 4 medication administration carts (Lower A hall and Lower B hall), failed to remove an expired multi-dose insulin pen injections in 1 of 4 medication administration carts (Lower A hall), and failed to discard loose pills in the medication administration cart drawer for 3 of 4 medication administration carts (Lower A hall, Upper and Lower B halls).

Findings Included:

1.

a. On 6/17/24 at 11:10 AM, an observation of the medication administration Lower A hall cart with Nurse #2 revealed one opened and undated multi-dose Lantus Glargine insulin pen injector, one opened Semglee Glargine insulin pen injector, one opened Humalog Lispro insulin pen injector, and one opened Basaglar insulin pen injector. A review of the manufacturer's literature indicated to discard Lantus, Semglee, Humalog and Basaglar insulin pen injectors 28 days after opening.

On 6/17/24 at 11:20 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin pens in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift.

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1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was affected by the deficient practice:

All expired insulin pens and loose pills were removed from the medication carts on (lower A hall, Upper and Lower B halls) on 6/17/2024 by the Unit Managers.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice:

All medication carts were audited on 6/17/2024 by the Unit Managers and any medications expired were discarded. All medication carts will be audited for any expired medications and loose pills weekly by the nurses assigned to each hall and reviewed and signed off by the unit Manager and or DON.

3. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur:

Education was provided to staff regarding checking expiration dates of medications on 7/09/2024, ensuring medications are stored appropriately, checking med cart drawers daily for loose pills and expired medications and disposing of them

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b. On 6/17/24 at 11:25 AM, an observation of the medication administration Lower B Hall cart with Nurse #6 revealed one opened and undated multi-dose Novolog insulin pen injector. A review of the manufacturer's literature indicated to discard Novolog insulin pen injector 28 days after opening.

On 6/17/24 at 11:35 AM, during an interview, Nurse #6 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift.

2. On 6/17/24 at 12:10 PM, an observation of the Lower A hall medication administration cart with Nurse #2 revealed one Aspart insulin flex Pen injector, opened on 5/10/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening (6/7/24); one Lispro Kwik Pen insulin injector, opened on 5/14/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening (6/11/24).

On 6/17/24 at 12:15 PM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding expired multi-dose vials. The nurse stated that she had not checked the date of

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properly.

All new licensed nurses will be educated on discarding expired medications and loose pills during orientation by the SDC Nurse.

4.The facility plans to monitor its performance to make sure that solutions are sustained:

Medication Carts will be audited weekly x 1 month, then bi-weekly xs 1 month to ensure compliance is sustained. Results of the audit will be reported to the Quality Assurance Performance Improvement Committee Monthly xs 2 for further problem resolution if needed.

The person responsible for the implementation and compliance of this plan of correction will be the DON.

Compliance Date: July 18, 2024

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opening on insulin pens in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift.

On 6/17/24 at 12:30 PM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date, and remove expired medications every shift. She expected that no expired items to be left in the medication carts.

3.
a. On 6/17/24 at 11:25 AM, an observation of the Lower B Hall medication administration cart with Nurse #6 revealed in the second draw of the medication cart, there were noted two white loose capsules, one blue round shape and one pink round shape loose pills.

On 6/17/24 at 11:25 AM, during an interview, Nurse #6 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #6 did not clean the cart before her shift.

b. On 6/17/24 at 1:30 PM, an observation of the Upper B Hall medication administration cart with Medication Aide #2 revealed in the second draw of the medication cart, there were noted four white loose round shape pills, two white capsules and one yellow round shape loose pills.

On 6/17/24 at 1:35 PM, during an interview, Medication Aide #2 indicated that she could not

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F 761	Continued From page 23 identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Medication Aide #2 did not clean the cart before her shift. c. On 6/17/24 at 1:40 PM, an observation of the Upper A hall medication administration cart with Nurse #5 revealed in the second draw of the medication cart, there were noted two white loose round shape pills. On 6/17/24 at 1:45 PM, during an interview, Nurse #5 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #5 did not clean the cart before her shift. On 6/17/24 at 2:25 PM, during an interview, the Director of Nursing (DON) expected that no loose pills be left in the medication carts.	F 761		
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.	F 812		7/18/24

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F 812 Continued From page 24

(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, interviews and record reviews the facility failed to discard expired foods and label and date foods placed in the reach-in refrigerator, walk-in refrigerator and in the dry storage area. The facility failed to maintain the stove's backsplash, side of the stove, oven, deep fryer clean and free of grease, and failed to maintain the silverware holder containing clean silverware free of dried food. The facility failed to maintain the floors of the walk-in refrigerator, walk-in freezer and dry storage clean and free of dirt. These practices had the potential to affect food served to residents.

Findings included:

1a. Observation of the reach-in refrigerator on 6/17/24 at 9 :18 AM, revealed a clean plastic container containing yellow colored food labeled " Lemon pudding " and 2 dates written on it "6/11/24 and 6/13/23". A clear plastic container filled with cut fruit labeled " Prep date 6/14/24" and "Use by date 6/16/24". A plastic container (Jug) one third filled with orange colored liquid with no lid or label on it. There were 18 cups containing fruit in a tray with no label or date on it. Two opened 42 fluid ounces (Fl. oz) carton labeled " Thickened sweet tea" with no open date. One opened 42 Fl. oz carton labeled "Thickened orange juice" with no opened date. A plastic container one fourth filled with reddish-purplish

F 812

1. Address how corrective action will be accomplished for those found to have been affected by the deficient practice: No resident was found to be affected by the affected practice.

On 6/17/2024 the lemon pudding, cut fruit labeled prep date, the plastic container with orange colored liquid, the 18 cups of fruit in tray with no label, food labeled jelly dated 6/5/2024, thicken liquid tea and thicken liquid orange juice, the expired 2% milk dated 6/11/2024, the half and half with best by 5/29/2024, sweet relish expired 5/29/2023 (in the dry storage area), Pancake and waffle syrup dated 12/14/21 (in the dry storage area) was discarded by the Dietary Manager.

2.All residents have the potential to be affected by the deficient practice:

The reach in refrigerator, and walk-in refrigerator was audited for expired foods, dry goods, and supplements on 6/17/24 and discarded by the Dietary Manager.

The walk-in refrigerator and walk in freezer were cleaned on 6/17/2024 by the Dietary Manager. The boxes of Ice cream

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food labeled " Jelly" and dated "6/5/24".

During an interview on 6/17/24 at 9:18 AM, the dietary cook stated any leftover food should be discarded in 3 days or by the date indicated on the label. She stated the yellow-colored food was pudding, and the cut fruit was mixed fruit. She indicated that both these foods should have been discarded. The cook indicated the yellow-colored liquid was orange juice and should have been covered and labeled. The cook indicated she had not worked on the weekend and unsure when the tray was placed in the refrigerator. She indicated all food placed in the refrigerator should be labeled and dated. The thickened liquids when opened should be labeled and dated and should be discarded within 3 days.

During an interview on 6/17/24 at 9:25 AM, the Dietary Manager indicated all thickened liquids when opened should be dated and discarded within 7 days. The Dietary Manager stated the thickened liquids were opened that morning (6/17/24) and staff had forgotten to date it. He stated all dietary staff were responsible to ensure the food was labeled and discarded appropriately. The DM stated the reddish-purple food was jelly used in making sandwiches and could be in the refrigerator for 10 days.

1 b. Observation of the walk-in refrigerator on 6/17/24 at 9:30 AM revealed a cardboard box containing 8 Fl. oz carton of 2 % milk with best by date "6/11/24". There were thirty-two (32) carton of milk in the box. Observation also revealed one quart carton " half and half" with best by date "5/29/24". A half-filled 2-liter soda bottled with no label.

and the unopen zucchini was removed from the walk-in Freezer floor and placed on the shelf.

3. On June 24th, 2024, the Dietary manager received and in-service on utilizing a daily schedule, weekly schedule, and monthly deep cleaning schedule by the Administrator.

On July 9,2024 the Dietary Staff and Dietary Manager received in-service on labeling with a date all prep, open food/containers, leftovers and dry goods.

In addition, Dietary Manager and Dietary staff received in-service on cleaning responsibilities and duties by the SDC Nurse.

All new dietary staff will receive education during orientation on labeling, discarding expired foods, drinks, dry goods and the daily cleaning schedule, weekly cleaning schedule and the Monthly deep cleaning schedule by the SDC Nurse.

4.The facility plans to monitor its performance to make sure that solutions are sustained:

The walk-in refrigerator, walk in freezer and dry storage area will be audited daily x□s 2 months then daily x□s 1 months, then daily x□s 3 weeks, then daily x□s 1 week by the Dietary Manager and signed off and given to the Administrator to review accuracy and sign off.

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F 812	Continued From page 26 During an interview on 6/17/24 at 9:30 AM, the Dietary Manager indicated he was unsure why the expired milk and the "half and half" carton were still in the refrigerator. He indicated they received new boxes of milk carton earlier in the morning (6/17/24) and the expired box of milk should have been discarded. The Dietary Manager was unsure to whom the soda bottle belonged to and indicated staff should not be placing their personal food in the refrigerator. 1 c. Observation of the dry storage area on 6/17/24 at 9:35 AM revealed an opened plastic bottled, half filled with greenish colored food. The label on the bottle indicated " Sweet relish" and had an expiration date on 5/29/23. Three (3) one gallon plastic containers labeled " Pancake and Waffle syrup" with date 12/14/21 on it. During an interview on 6/17/24 at 9:35 AM, the Dietary Manager indicated he had never seen these plastic containers and unsure when the expiration date of the syrup was. During an interview on 6/18/24 at 11:40 AM, the Regional Director for Environmental service and Dietary stated per vendor's email, if the syrup was stored in glass bottles it was good for 4 years and if the syrup was stored in plastic bottles it was good for 2 years from the date written on the containers. As the syrup was in plastic bottles, these bottles had to be discarded. 2 a. Observation of the reach-in freezer on 6/17/24 at 9:15 AM revealed ice and dried food on the floor of the freezer. During an interview on 6/17/24 at 9:15 AM, the dietary cook indicated she was not sure why the freezer was not cleaned.	F 812	The daily cleaning schedule will be audited daily x□s 1 month, then weekly x□s 1 month by the Dietary Manager and signed off for accuracy and given to the Administrator for review and audit for accuracy and sign off. The weekly cleaning schedule will be monitored weekly x□s 1 month by the Dietary Manager and signed off for accuracy. The monthly deep cleaning schedule will be monitored monthly x□s 2 months then monthly x 1 month by the Dietary Manager and signed off for accuracy. The monthly deep cleaning schedules shall be brought to the monthly Quality Assurance Performance Improvement Committee Meeting x□s 3 months to review the results and to ensure compliance is sustained. The person responsible for the implementation and compliance of this plan is the Administrator. Compliance Date: 7/18/2024	

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2. b Observation of the walk-in refrigerator on 6/17/24 at 9:30 AM revealed pieces of paper (package paper and tape pieces) under the racks and red colored fluid puddle on the floor.

During an interview on 6/17/24 at 9:30 AM the DM stated it was some accident that the dietary staff did not clean the refrigerator after they pulled the food out of the rack. He was unsure what the red colored fluid on the floor was.

2 c. Observation of the walk-in- freezer on 6/17/24 at 9:35 AM, revealed a greenish- bluish liquid on the floor. 4 big cardboard boxes of ice cream and a white colored cardboard box containing bags of frozen zucchini (unopened) on the floor.

During an interview on 6/17/24 at 9:35 AM, the Dietary Manager indicated the ice cream boxes belonged to the activities department as the facility had celebrated Nurse Aides last week. The Dietary Manager indicated it was the responsibility of all dietary staff to ensure that the floor of the refrigerator or freezer were clean.

2 d. Observation of the dry storage on 6/17/24 at 9:40 AM revealed multiple pieces of packing paper, dust and dirt on the floor. The Dietary Manager indicated they received their supplies from their vendor earlier that morning. He further indicated that the dry storage floor was cleaned once a week after the supplies were stocked.

3a. Observation of the stove on 6/17/24 at 9:40 AM revealed the side of the cooking range and the back splash had blackish greasy stains. During an interview on 6/17/24 at 9:40 AM, the

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Dietary Manager stated the dietary staff cleaned the stove/range weekly and they had been working hard to get the grease stain out from the back splash.

3b. Observation of the oven on 6/17/24 at 9:40 AM and on 6/18/24 at 11:45 AM revealed dried brown stains on the inside of the oven door. Greasy, brown burnt stains were also observed on the racks and floor of the oven. The Dietary Manager stated the oven was used daily and cleaned only weekly.

3c. Observation of the deep fryer on 6/17/24 at 9:40 AM revealed light brown oily stains in the front and side of the equipment. The Dietary Manager stated the deep fryer was cleaned once a week and he was responsible for cleaning the deep fryer.

3d. Observation of the steam table on 6/17/24 at 9:15 AM revealed a silverware holder containing clean silverware (forks, and spoon) having dried food particles and brownish colored fluid at the base of the holder.

During an interview on 6/17/24 at 9:15 AM, the dietary cook indicated she was unsure why the silverware holder had the food particles and that it should be sent back to the dish washer to be washed again.

3e. Observation of the air-dry rack holding clean dishes on 6/17/24 at 9:15 AM and on 6/18/24 at 11;45 PM revealed a crate containing clean plates. There were multiple opened plastic bags containing plastic cup covers on these clean plates.

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F 812	Continued From page 29 During an interview on 6/17/24 at 9:15 AM, the dietary cook indicated staff should not be placing anything on the clean dishes rack while the clean dishes were air dried. She further stated the plates would be sent to the dishwasher to be washed and sanitized. During an interview on 6/18/24 at 11:45 AM the Dietary Manager stated the cup covers/ lids should not be placed on clean dishes. The plates would be sent back to the dishwasher to be washed again. Review of the document " Weekly Game Plan AM/PM staff 6/9 - 6/16/24 " indicated the names of staff that were responsible to clean the oven, dry storage room. Staff initials were on the side of the items they were responsible for cleaning, indicating it was clean by the assigned staff. The documents also indicated the Dietary Manager was responsible for cleaning the deep fryer and it indicated it was cleaned with his staff initial. Weekly cleaning document for 3 months were reviewed, and all documents had the initials of the staff indicating the assigned equipment was cleaned. During an interview on 6/18/24 at 3:00 PM, the Dietary Manager stated the dietary department had only weekly schedules and did not have any document that indicated daily schedules. All staff were responsible for cleaning after each task they had completed. During a reinterview with the Dietary Manager on 6/20/24 at 11:13 AM, he stated any leftover or prep food should be discarded within 7 days. The food should be labeled with a "prep date" and	F 812		

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F 812	Continued From page 30 "use by date" and when by the "use by date". The Dietary Manager stated opened thickened liquids should be labeled with "open date" and should be discarded within 7 days of opening. Regarding cleaning schedules, he indicated he had not been using daily cleaning schedules and followed only weekly cleaning schedule. For daily cleaning, the dietary staff were responsible to clean after themselves daily. He further indicated he was also responsible for cleaning the kitchen daily. The Dietary Manager stated he cleaned the deep fryer twice a week. The dietary staff cleaned and mopped the walk-in refrigerator three times a week. The dry storage was swept and mopped daily, and the dietary cooks were responsible. He indicated he was responsible for checking food in the walk-in and reach refrigerator and freezer and discarding any expired food. During an interview on 6/20/24 at 11:24 AM the Regional Director for Environmental service and Dietary stated the Dietary Manager was provided with daily cleaning schedules and was unsure if it was appropriately followed. The weekly cleaning schedule was the deep cleaning schedule, and this should be followed by every dietary staff who have been assigned to the task. She further stated the Dietary Manager was responsible to ensure the daily cleaning and weekly cleaning schedule were appropriately completed by the staff. the Regional Director for Environmental service and Dietary stated the Dietary Manager should do a complete walk thoroughly of the refrigerator and Freezer and the kitchen twice a day. The food placed in the refrigerator should be labeled by the prep date and discard date and all staff would be educated on discarding food 7 days from the prep day. She indicated the thickened liquids should be dated when opened	F 812		

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F 812	Continued From page 31 and discarded within 7 days. The racks used for clean dishes should always be holding only clean dishes. During an interview on 6/20/24 at 5:24 PM, the Administrator stated the Dietary Manager was responsible to ensure the cleaning schedules were followed by the dietary staff, ensure that all foods were labeled and expired food discarded. All equipment should be maintained clean and free of any grease and food particles. Both daily and weekly scheduled should be followed by all dietary staff. The Dietary Manager should be doing a walkthrough of the kitchen 2 times a day to ensure the areas were clean, expired food discarded and food was labeled appropriately.	F 812		
F 924 SS=E	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to ensure the handrails in the facility corridors were properly secured to the walls, repaired and free from sharp edges on 3 of 3 halls where handrails were present. The findings included: An observation was conducted on 6/17/24 tour of facility 9:45 AM, revealed on the A hall the handrails were needed repairs due to broken/cracked and missing end caps in the corridor joining the A facility hall bathroom and rooms A1, A3, A6, A 11, A15, A17, A25, A26,28,	F 924	1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was affected by the deficient practice. On 6/20/24 the Maintenance Director conducted an audit on hall A , hall C, and hall B to see what handrails needed to be repaired, to obtain measurements and to order the correct parts. 2. All residents have the potential to be affected by the same deficient practice:	7/18/24

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A29 and the resident shower room on A hallway. The end of the handrails had sharp edges that were not covered by the endcaps. Staff and residents were observed using the handrails in the current condition.

An observation was conducted on 6/17/24 at 10:00 AM, revealed on the C hall the handrails need repairs due to broken/cracked and missing end caps in the corridor joining the storage area between and room C27.

An observation on 6/17/24 at 10:30 AM, revealed on the B hall the handrails needed to be repaired due to broken/cracked and missing endcaps in the corridor joining the B hall resident shower room, medical supply room, resident rooms B 7 , B16, B20, B21, and B25.

A follow-up observation was conducted on 6/19/24 at 9:30 AM, revealed the identified handrails in the A hall, B hall and C hall remained in the same condition and had not been repaired. Staff and residents continued to use the handrails for support during mobilization on the units.

An observation and interview were conducted on 6/19/24 at 10:30 AM with the Maintenance Director who stated he started the position on 6/17/24. He stated he was not aware of all the environmental needs of the facility and planned to discuss any of the observations and concerns with the administrator and housekeeping supervisor. He was unaware of the current system in place to ensure repairs were completed.

An interview was conducted on 6/19/24 at 11:43 AM, the Administrator who stated the facility

F 924

On 6/20/2024 the Maintenance Director order the parts that was needed to repair and replace all broken and cracked and missing end caps on hall A, hall C and hall B. On 6/25/24 all broken and cracked and missing end caps on hall A, hall C, and hall B were replaced by the Maintenance Director on 6/25/24.

3.The measures that was put in place to ensure that the deficient practice will not recur: Educational in-service was provided to the Maintenance staff on conducting repairs that are needed within the facility within a timely manner if minor repairs within three to ten working days, if major repairs within 30 or more working days.

All nursing departments heads, floor nurses and environmental heads was trained on how to enter a work order in TEL�s for repairs in the facility.

4.The facility plans to monitor it performance to make sure that solutions are sustained:

The Maintenance Department will conduct weekly audits x�s 1 month then weekly x�s 3 weeks, then weekly x�s 2 weeks to ensure all handrails are intact.

The results of the audits will be presented to the Quality Assurance Performance Improvement Committee x�s 1 month to ensure compliance is sustained.

The person responsible for the

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F 924	Continued From page 33 Environmental Service Director and Maintenance Director was responsible for ensuring the facility was clean and structural repairs were completed for the safety of all the residents. She included a handrail and resident room audits would be done for repairs and replacement immediately based on the recent facility assessment. She indicated the Maintenance Director and additional housekeeping staff were recently hired on 6/17/24.	F 924	implementation and compliance of this plan of correction will be the Administrator. Compliance date: 7/18/2024	