STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824350	A. BUILDING _____ B. WING _____	**12/6/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR SEASONS NURSING CENTER OF WESTLAND	**8365 NEWBURGH RD WESTLAND, MI 48185**

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F0000 SS=	INITIAL COMMENTS Four Seasons Nursing Center of Westland was surveyed for a Recertification survey on 12/6/2023. Intakes: MI00136173, MI00138504, MI00138662, MI00139550, MI00140387, MI00140917, MI00140978, and MI00141344. Census= 151	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The	F0550	F550- Identified practice 1- Element #1 R27 continues to reside in the facility. R27 was provided with a pillowcase upon identification of the identified practice. R27's skin was evaluated, and no skin injury was noted to have resulted from the identified practice. Element #2 All residents who reside in the facility are determined to be like residents. An audit of all residents was completed, and all residents were provided with a pillowcase. Element #3 The facility policy on Dignity was reviewed and deemed appropriate for education. Nursing staff were educated on the facility Dignity policy with a focus on ensuring residents are provided with pillowcases. Element #4 DON/Designee will randomly audit 5 residents in the facility to ensure they have been provided with a pillowcase. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained.	12/29/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/19/2023

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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	resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure dignity during care for one (R27) of eight residents reviewed for resident rights and dignity. Findings include: Review of the facility record for R27 revealed an admission date of 02/04/19 with diagnoses that included Dementia, Psychotic Disorder with Delusions and Anxiety Disorder. The Minimum Data Set (MDS) assessment dated 08/07/23 indicated that the resident required primarily total assistance with activities of daily living and demonstrated severe cognitive impairment. On 12/05/23 at 3:39 PM, R27 was observed laying in bed. There was no pillow case on the pillow or laying nearby and therefore the resident's head/face was resting on the plastic pillow covering. The surveyor attempted to interview the resident regarding the sling and they were responsive but not able to communicate functionally during this interaction. On 12/06/23 at 9:13 AM, R27 was observed		The DON is responsible for substantial compliance. F550- Identified practice 2- Element #1 R27 continues to reside in the facility. No mood or behavior changes were reported as a result of the identified practice. Element #2 All residents who are dependent on staff for care are determined to be like residents. All dependent residents residing in the facility were observed randomly receiving personal care to ensure they were provided with privacy during personal care. Element #3 The facility policy on Dignity was reviewed and deemed appropriate for education. Nursing staff were educated on the facility Dignity policy with a focus on ensuring residents are provided with privacy during personal care. Element #4 DON/Designee will randomly audit 5 residents who are dependent on staff for care in the facility to ensure they have been provided with dignity during personal care. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance.	

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	from the hallway receiving completion of peri-care and having their brief and pants donned by Registered Nurse (RN) "J". The resident's door was fully open and the privacy curtain was not pulled exposing the resident during the care from the hallway. On 12/06/23 at 9:26 AM, RN "J" was asked about the surveyor's observation of R27 being changed/dressed with the curtain and the door open and observable from the hallway. RN "J" reported that the standard procedure was to provide privacy to the resident and they acknowledged that they had not done so. On 12/06/23 at 12:43 PM, the facility Administrator (NHA) reported that the expectation regarding use of pillow cases is that resident pillows should have a case on unless requested or care planned otherwise. The NHA reported that the expectation regarding resident privacy during personal care is that the curtain should be pulled and the door should be shut, providing full privacy from the hallway. On 12/06/23 at 1:22 PM, the facility Director of Nursing (DON) reported that the expectation regarding pillow cases is that a resident be provided with a pillow case rather than using the plastic uncovered pillow, unless care planned otherwise. The DON reported that the expectation regarding privacy during personal care is that a resident's curtain be pulled and the door shut			

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	during provision of personal care in the bed. Review of the facility policy titled "Dignity" dated 09/21/23 revealed inclusion of the "General Guidelines" statement "Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures".			
F0657 SS= D	Care Plan Timing and Revision §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 by:	F0657	F657- Care Plan Timing and Revision Element #1 R137 continues to reside in the facility and has experienced no further incidents. R137 was provided with dycem to his bed upon identification of the identified practice. His care plan was reviewed and updated to reflect the implemented intervention to reduce risk for falls. Element #2 Residents who have experienced a fall are determined to be like residents. An audit of all residents who experienced falls in the prior 30 days was completed and the facility confirmed their care plans had been updated with implemented interventions to reduce risk for falls in place. The facility confirmed care planned interventions r/t the falls were in place. Element #3 The facility policy on Care Plan-Comprehensive and Revision was reviewed and deemed appropriate for education. Nursing staff were educated on the facility Care Plan- Comprehensive and Revision policy with a focus on ensuring interventions implemented to reduce risk for falls are in place and present in the care plan. Element #4 DON/Designee will randomly audit 5 residents	12/29/2023

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	Based on observation, interview, and record review the facility failed to revise and implement an intervention on the care plan for one resident (R137) from a sample of 10 residents reviewed for care plans following a fall. Findings include: A review of R137's medical record revealed that they were admitted into the facility on 12/15/22 with diagnoses that included Cerebral Infarction, Dysphagia, Encounter for attention to tracheostomy, Diabetes and Anxiety. Further review revealed a quarterly Minimum Data Set assessment dated 9/22/23 indicating that the resident was cognitively intact and required total dependence for all Activities of Daily Living. A review of R137's Incident and Accident reports revealed that on 11/20/23, the resident sustained a fall. A review of R137's progress notes revealed the following progress note: "11/30/202310:05 (10:05am) Case Mgnt (management) Note Text: Reviewed by IDT (interdisciplinary team) r/t (related to) recent unintentional change in elevation. The root cause was identified as resident sliding in bed d/t (due to) having an air mattress. The intervention implemented to reduce risk for future falls was dycem (nonskid pad) was applied to [their] bed between the mattress and the sheet. This intervention has proven to be effective". A review of R137's care plan revealed the following: Focus: [R137] is at Risk for Falls and Potential for Injury r/t: Deconditioning, Left sided hemiplegia and psychotropic med use. Date Initiated: 12/24/2022..." Further review of the care plan revealed that there were no new interventions or revision made to the		who have experienced a fall in the prior 30 days to ensure recommended interventions implemented to reduce risk for falls are in place and present in the residents care plan. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance.	

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	care plan after R137's 11/20/23 fall. On 12/5/23 at 2:49 PM, Unit Manager "P" and Unit Manager Q"" were asked to locate the dycem underneath R137 however, upon observation, it was not there. On 12/6/23 at 1:17 PM, the Director of Nursing (DON) was asked about expectations for fall interventions being implemented, and explained that his expectations are that interventions are in place. A review of the facility's "Care Plan-Comprehensive and Revision" policy was reviewed and revealed the following, "Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: This citation pertains to Intakes MI00136173, MI00138504, and MI00138662.	F0677	F-677 Identified practice 1- Element #1 R9 continues to reside in the facility. Her skin was evaluated and no ill effects were identified related to the identified practice. Element #2 All residents who reside in the facility are determined to be like residents. An audit of all residents was completed and the facility confirmed they were receiving their showers per their plan of care. Element #3 The facility policy on Activities of Daily Living was reviewed and deemed appropriate for	12/29/2023

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	Based on observation, interview, and record review the facility failed to provide activities of daily living care (ADLs) for two dependent residents (R9 and R77) of nine residents reviewed for ADL care, resulting in feelings of frustration. Findings include: R9 On 12/4/23 at 10:52 AM, during an initial tour of the facility R9 was interviewed and asked about the care they received at the facility. R9 indicated that they did not receive enough showers. R9 stated, "I don't receive showers on my scheduled shower days." On 12/5/23 at 12:02 PM, a thirty day review of R9's shower documentation in their electronic medical record (EMR) revealed that R9's scheduled shower days were Fridays and Tuesdays, and that R9's documented showers during the thirty day review period revealed that R9 had been offered showers on 11/7/23, 11/24/23, and 11/29/23 indicated, "Activity did not occur." No other shower documentation was indicated for R9. On 12/5/23 at 12:47 PM, R9's ADL care was reviewed and revealed no observed shower interventions on R9's care plan. On 12/5/23 at 12:49 PM, paper documentation of R9's shower activity over the past thirty days was reviewed and revealed that R9 had been offered showers on 11/7/23, 11/14/23, 11/21/23, and		education. Nursing staff were educated on the Activities of Daily Living policy with a focus on ensuring residents receive showers per their plan of care. Element #4 DON/Designee will randomly audit 5 residents to ensure they have received showers per their plan of care. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance. F-677 Identified practice 2 Element #1 R77 continues to reside in the facility. She was evaluated for unplanned weight loss and it was determined that they experienced no change in nutritional status from the identified practice. Element #2 All residents who are dependent on staff for feeding assistance are determined to be like residents. An audit of all residents who are dependent on staff for feeding assistance was completed and the facility confirmed they received feeding assistance from staff per their plan of care. Element #3 The facility policy on Assistance with Meals was reviewed and deemed appropriate for education. Nursing staff were educated on the Assistance with Meals Policy with a focus on ensuring residents who are dependent on staff for feeding assistance received feeding assistance per their plan of care. Element #4 DON/Designee will randomly audit 5 residents	

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	11/24/23. No other shower documentation was indicated for R9 over the past thirty days. On 12/5/23 at 12:53 PM, further review of R9's EMR revealed that R9 was admitted to the facility on 7/9/22 with diagnoses that included Type 2 diabetes and Major depressive disorder. R9's most recent minimum data set assessment (MDS) dated 9/29/23 revealed that R9 had an intact cognition and required extensive one to two person assistance for all ADL's other than eating. On 12/6/23 at 12:09 PM, the administrator (NHA) was interviewed about their expectations for residents showers and documenting the offering of showers to residents. The NHA stated, "That has been a work in progress, they should be getting them on their scheduled day or as requested. We are reviewing showers daily and checking with the nurse and aides prior to end of shift to ensure the shower was completed. We are asking that the CNAs (Certified Nursing Assistants) go to the nurse when there is a refusal. We definitely need to improve on it." On 12/6/23 at 12:58 PM, R9 was further interviewed about their ADL care/showers at the facility and stated, "I get frustrated when I don't receive my showers. I have a catheter so I need the urine smell cleaned regularly." On 12/6/23 at 1:05 PM, CNA "O" was interviewed about their ability to complete		who are dependent on staff for feeding assistance to ensure they have received feeding assistance from staff per their plan of care. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance.	

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	care tasks for residents. CNA "O" stated, "At times it can be tough. We have high acuity (severity of illness) residents on this unit." R77 On 12/6/2023 on 9:20 AM, R77 was observed in their room. R77 was observed laying in bed with the bed of their raised up. R77 was noted to have a breakfast tray in front of them and feeding themselves. R77 was noted to be coughing while eating. No staff member was noted to be in the room. A review of the medical record revealed that R77 admitted into the facility on 9/7/2022 with the following diagnoses, Dementia, Aphasia, and Cerebral Infarction. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 1/15 indicating a severely impaired cognition. R77 also required extensive one to two person assist with transfers and bed mobility. A review of R77's speech discharge note revealed the following, "Discharge Status and Recommendations...Patient is dependent for all feedings." On 12/6/2023 at 9:25 AM, Registered Nurse (RN) "G" was brought into the room and was asked if R77 was supposed to be eating alone. RN "G" stated that R77 is supposed to be a 1:1 feed assistence. On 12/6/2023 at 12:02 PM, an interview was			

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	conducted with Speech Language Pathologist (SLP) "I". SLP "I" stated that R77 is dependent for feeding, meaning that they are an 1:1 feed. assistance. On 12/6/2023 at 12:54 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding their expectations on 1:1 assistance with meals. The NHA stated that is someone is dependent for feeds, then they should be fed. On 12/6/2023 at 1:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if someone is an 1:1 feed then it is in the kardex (guide that indicates a residents individualized needs), as well as in their room. Review of a facility policy titled, "Activities of Daily Living (ADL) Issued Date: 8.21.2023" was reviewed and stated the following, "Policy Overview: "...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good...grooming and...personal hygiene." A review of a facility policy titled, "Assistance with Meals" noted the following, " ...C. Patient/residents who cannot feed themselves will be fed with attention to safety, comfort and dignity per Plan of Care."			
F0684	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that	F0684	F-684- Identified practice 1 Element #1	12/29/2023

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SS= D	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation has two Deficient Practice Statements: Deficient Practice Statement #1. Based on observation, interview, and record review, the facility failed to follow speech recommendations for one residemt (R77) out of two reviewed for speech. Findings include: On 12/6/2023 on 9:20 AM, R77 was observed in their room. R77 was observed laying in bed with the bed of their raised up. R77 was noted to have a breakfast tray in front of them and with a coffe cup, a straw was noted to be in the cup. A sign was observed on the wall that noted R77 was not supposed to have straws. A review of the medical record revealed that R77 admitted into the facility on 9/7/2022 with the following diagnoses, Dementia, Aphasia, and Cerebral Infarction. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 1/15 indicating an impaired cognition. R77		R77 continues to reside in the facility. Her physician's order was updated to reflect that she is allowed to have straws per ST recommendations. The sign in her room indicating that she should have no straws was removed to match current ST recommendations. R77 experienced no ill effects from the identified practice. Element #2 All residents who receive recommendations from speech therapy are determined to be like residents. An audit of residents who received recommendations from speech therapy in the previous 30 days were audited to ensure speech therapy recommendations were followed. Element #3 The facility protocol on communication of ST recommendations were reviewed and updated to ensure proper communication between the speech therapist and the IDT. The IDT and speech therapist were re-educated on the communication protocol for ST recommendations. Element #4 DON/Designee will audit 5 residents who receive recommendations from the speech therapist to ensure recommendations are carried through to physician□s orders, care plan, and Kardex. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance. F-684- Identified practice 2 Element #1 R137 continues to reside in the facility.	

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	also required extensive one to two person assist with transfers and bed mobility. On 12/5/2023 at 9:30 AM, a review of R77's diet order revealed the following, "Order Date:9/7/2023...Order Summary: Regular Diet ...Pureed texture,Moderate/Honey consistency, for No Straws,handled cups for all beverages. On 12/6/2023, an additional review of R77's diet order revealed the following, "Order Date: 12/5/2023 ...Order Summery: ...May have straws." On 12/6/2023 at 10:07 AM, an interview was conducted with the Director of Rehabilitation (DOR) "H". DOR "H" stated that they changed the diet order for R77 to have straws. DOR "H" stated that R77 was discharged from speech services in November and the speech therapist stated that R77 could dhave straws. On 12/6/2023 at 12:02 PM, an interview was conducted with Speech Language Pathologist (SLP) "I". SLP "I" stated that R77 was discharged from speech services in November and that they were able to have straws. SLP "I" stated that the order and the sign by the bed should have been changed in November when R77 was discharged from services. On 12/6/2023 at 11:54 AM, an interview was conducted with the Nursing Home Amdinistrator (NHA) regarding following		Resident's weight continues to be within a normal BMI for his height. Upon investigation of the concern by the IDT, it was identified that the decrease in weight was expected after the acute condition during the rehospitalization and resident refusal of tube feeding. His BMI remained within the normal range for his height and no ill effects were noted from the identified practice. Documentation was updated to reflect interventions implemented at the time of the weight loss. Element #2 All residents who receive tube feeding are determined to be like residents. An audit of residents who received tube feeding was completed to ensure they experienced no undesired weight loss, that any residents who refused tube feeding had documentation entered to reflect this, and that any resident desiring weight loss had documentation entered to reflect the discussion with the resident and/or their representative. Element #3 The facility Weight Policy was reviewed and deemed to be appropriate for education. The IDT were re-educated on the Weight Policy with a focus on timely implementation and documentation of interventions for weight loss, documentation of tube feeding refusals, and ensuring discussion of the desire for weight loss with the resident and/or resident's representative. Element #4 Dietitian/Designee will audit 5 residents who receive tube feeding to ensure there is no undesired weight loss, that any residents who refused tube feeding had documentation entered to reflect this, and that any resident desiring weight loss had documentation entered to reflect the discussion with the resident and/or their representative. The audit	

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	speech recommendations. The NHA stated that they believe it was a breakdown in communication and that they will be working on it. On 12/6/2023 at 1:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that they looked into what happened and will figure out a better way to communicate speech recommendations. A review of a facility policy titled, "Therapy Evaluation" did not address following speech recommendations. Deficient Practice statement #2. Based on observation, interview, and record review, the facility failed to timely implement, and document interventions for weight loss, document tube feeding (TF) refusals, and discuss the desire for weight loss with resident and resident's representative for one sampled resident (R137) of two residents reviewed for weight loss. Findings include: On 12/4/23 at 9:12 AM, R137 was observed in bed asleep. Nutren 2.0 was hanging at 83ml/hr (milliliters per hour) ×13hrs with auto flush 50ml/hr×13hrs. A review of R137's medical record revealed that they were admitted into the facility on 12/15/22 with diagnoses that included Cerebral Infarction, Dysphagia, Encounter for attention to tracheostomy, Diabetes and Anxiety. Further review revealed a quarterly Minimum Data Set assessment dated 9/22/23 indicating that the		will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The dietitian is responsible for substantial compliance.	

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	resident was cognitively intact and required total dependence for all Activities of Daily Living. Further review of R137's medical record revealed the following progress notes: 9/21/2023 12:01 Case Mgnt (management) Note Text: Reviewed by IDT (interdisciplinary team) r/t (related to) weight loss- [R137] desires weight gain and will have tube feeding increased to meet [their] desires. [R137] was educated that their BMI (body mass index) is where it should be and [R137] states that [they] would prefer to continue gaining weight with a goal of approximately150 lbs." 9/28/2023 12:04 Case Mgnt Note Text: Reviewed r/t weight loss of 20lbs (pounds) over three months to a normal BMI. Tube feeding has been adjust (adjusted) to assist [R137] in gaining weight which is [their] wish even though [their] current BMI is WNL (within normal limits). [R137] has been educated on this topic and chooses to continue to gain weight. Provider is aware of this." Further review of R137's medical record revealed that R137 had triggered for weight loss June 2023 as evidenced by the following progress note: "6/23/202313:44 (1:44pm) Nutrition/Dietary Note Text: Quarterly Nutrition Review: Ht (height): 66 inches; Wt (weight) (6/23): 137# (pounds); BMI (body mass index)= 22.1; indicative of Normal; 30d (days): 153# 5/10; 90d:152# 3/13; 180d: 155.5# 12/16. Significant Wt. Change: yes -18.6# -12.0% in 6 months Diet: NPO (nothing by mouth)			

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	Enteral Feeding: Nutren 2.0 78 ml/hour x12 Hours = 936 ml/1872 kcal (kilo calories) Up at 8pm down at 8am; Auto flush 50 ml/hr x 12hours = 600 ml while TF running Labs No new labs; Skin: intact Summary & Recommendations: Resident is NPO Tolerating Tube feeding well. Nutrition Dx (diagnosis): [Blank] RD recommendations: 1. Continue with diet as ordered 2. Continue Tube feeding as ordered 3. Meds/labs as ordered 4. Continue monthly weight tracking RD (registered dietician) to monitor weights, labs, skin condition,and Tube feeding tolerating with no N/V/D/C (nausea, vomiting, diarrhea, constipation) Will review and update CP (care plan)." Further review of R137's medical record did reveal that the resident was admitted into the hospital from 5/28/23 to 6/5/23 for Pneumonia however, R137's hospital paperwork dated 5/29/23 revealed that the resident's weight was 110 pounds upon admission into the hospital. Further review of R137's weights following readmission into the facility revealed the following:			

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	6/23/23: 137 pounds 7/21/23: 137.2 pounds 8/14/23: 137 pounds 9/6/23: 137 pounds A review of R137's care plan revealed the following care plan: "Focus: Resident is NPO (nothing by mouth) with all nutrition and hydration provided via feeding tube Dysphagia, with risk of dehydration. June 2023: Resident triggers for a significant weight loss on readmission (x 30 days). Date Initiated: 12/20/2022..." Further review of R137's care plan revealed that there were no new interventions following the resident's weight loss nor was there documentation regarding the resident's desire to lose weight. On 12/6/23 at 11:22 AM, an interview was completed with (RD) Registered Dietician "N" regarding R137's weight loss. RD "N" explained that the resident's largest weight loss was in June, and that R137 had been refusing their tube feeding formula because it was "giving them hiccups." RD "N" explained that the resident refused the tube feeding for three months. RD "N" was asked what type of intervention was put into place to address the weight loss and refusals, and she explained that the resident indicated that they did not want a different tube feeding formula, and did not offer any other explanation. RD "N" explained that the resident has recently begun to gain weight because the resident and their power of attorney wanted the resident to gain weight, so the tube feeding was increased. RD "N" was asked who would be documenting refusals, and she indicated that nursing would			

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	document refusals and should be entering the milliliters the resident was consuming at a time. A review of R137's Medication Administration Record for May 2023, June 2023, July 2023 and August 2023 revealed no documented refusals for the resident's enteral feeding. On 12/6/23 at 1:17 PM, the Director of Nursing (DON) was asked about the weight loss of R137 and explained the interventions that he has made since entering into the role of DON in which the IDT (Interdisciplinary team) meets, discusses interventions, and reviews the resident's medical record. The DON explained that if there was a problem before, there isn't one now, as all residents are being monitored for weight loss. A review of the facility's "Weight" policy revealed the following, "1.The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: a. Identifying and assessing each resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary 2. A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status. 3. Information gathered from the nutritional assessment and current dietary standards of			

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	practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. 4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status..."			
F0688 SS= D	Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to apply knee braces for one resident (R133) out of two reviewed for range of motion. Findings include: A review of the medical record revealed that	F0688	F-688- Increase/Prevent Decrease in ROM/Mobility Element #1 R133 continues to reside in the facility. She did not experience any changes in health status as a result of the identified practice. The facility assessed R133 to determine if knee braces remain clinically appropriate. R133 had pre-existing limitation in ROM prior to recommended knee braces with no increase in limitation to ROM identified. Upon assessment, R133, who is under hospice care verbalized discomfort when knee braces are applied and prefers they not be applied. The center notified the provider and an order was obtained to discontinue the knee braces. Element #2 All residents who have a recommendation for orthotic devices are determined to be like residents. An audit of residents who have recommendations for orthotic devices was completed to ensure orthotic devices have appropriate physician's orders. Element #3 The facility Restorative Nursing Programs was reviewed and deemed to be appropriate for education. Nursing staff were re-educated on the Restorative Nursing Programs policy with a focus on application of orthotic devices per physician's orders.	12/29/2023

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	R133 admitted into the facility on 10/4/2022 with the following diagnoses, Legal Blindness and Muscle Weakness. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 5/15 indicating an moderatly impaired cognition. R133 was also dependent on staff for bed mobility and transfers. A review of the physician orders revealed the following, "Frequency: Every Shift. Schedule Type: Everyday. Facility Time Code: 12 Hour Evry Shift. For (Indications for Use): Bilateral Knee Splints to prevent contractures." On 12/4/2023 at 12:25 PM, R133 was observd in bed. No knee braces were seen in place. On 12/5/2023 at 9:00 AM, R133 was observed in bed. No Knee braces were observed in place. On 12/5/2023 at 12:23 PM, R133 was observed in a geriatric chair. No Knee braces were observed in place. On 12/6/2023 at 9:40 AM, R133 was observed in bed with knee braces in place. On 12/6/2023 at 11:54 AM, an interview was conducted with the Nursing Home Adminsitrator (NHA). The NHA confirmed the order for R133 documenting that the braces should be on for twelve hours and off for twelve hours. The		Element #4 DON/Designee will audit 5 residents who receive orthotic devices to ensure orthotic devices are applied per physician's orders. The audit will occur weekly x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance.	

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	NHA stated that it should be a combination of restorative putting them on and nursing taking them off. On 12/6/2023 at 1:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that their understanding is that the care plan and kardex were resolved because R133 was not tolerating them, however the order was still active. The DON stated that the order should have been discontinued as well. A review fo a facility policy titled, "Restorative Nursign Programs" revealed the following, " It is the policy of this facility to provide maintanence and restorative services designed to maintain or improve a resident's abilities to the highest practicable level."			
F0761 SS= D	Label/Store Drugs and Biologicals §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	F0761	F-761- Label/Store Drugs and Biologicals Element #1 R254 continues to reside in the facility. She did not experience any changes in health status as a result of the identified practice. Element #2 All residents who receive oral medications are identified as like residents. An audit of all residents who receive oral medications was completed to ensure their medications were not left at the bedside. Element #3 The facility Medication and Treatment Storage policy was reviewed and deemed to be appropriate for education. Licensed nurses were re-educated on the Medication and Treatment Storage policy with a focus on ensuring medications are not left at the	12/29/2023

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	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain medications in a safe manner for one sampled resident (R254) of one reviewed for medication storage. Findings include: On 12/4/23 at 9:04 AM, R254 was observed sitting up in bed eating breakfast. A medication cup full of medications were observed sitting on their overbed table. R254 was asked about the medications, and stated that they would take the medications after they finished their breakfast. R254 was asked how many medications they had to take, and was observed to count the medications indicating that there were eight medications, including a large potassium pill that needed to be "melted". On 12/4/23 at 9:55 AM, R254 was observed to still have the medication cup sitting on their overbed table with one pill remaining in the cup. A review of R254's medical record revealed that the resident was admitted into the facility on 11/21/23 with diagnoses that		bedside. Element #4 DON/Designee will audit 5 residents who receive oral medications to ensure medications are not left at the bedside. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance.	

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	included Acute Kidney Failure, Muscle Weakness, and Hyperlipidemia. Further review of the resident's medical record revealed that the resident was cognitively intact and required 1 person assist for bed mobility, dressing, and personal hygiene. Further review of R254's medical record revealed a December Medication Administration Record revealed that all eight of the resident's medications had been administered at 9:00 AM. Further review of R254's medical record revealed that the resident did not have an assessment or any documentation noting that they were able to safely self-administer their own medications. On 12/6/23 at 1:17 PM, the Surveyor explained the observations of medications at the resident's bedside to the Director of Nursing, and asked for his expectations medication administration. He explained that his expectation is that nurses remain with residents until their medications are taken. A review of the facility "Medication and Treatment Storage" policy revealed the following, "During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart..."			

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F0804 SS= D	Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: This citation pertains to Intakes MI00138504 and MI00138662 Based on observation, interview, and record review, the facility failed to ensure that food was served in a palatable manner and at the preferred temperature for two residents (R9 and R116) of four residents reviewed for food palatability, resulting in dissatisfaction during meals. Findings include: On 12/4/23 at 10:47 AM, during an initial tour of the facility R9 was interviewed about the palatability of the food at the facility and indicated that their food was, "Frequently cold." On 12/4/23 at 1:24 PM, R116 was interviewed about the palatability of the food at the facility and indicated that the food didn't taste good and was cold. An observation of R116's lunch meal revealed that R116 had eaten their hamburger patty, their hamburger bun and french fries were uneaten on their plate. R116 was asked about the uneaten	F0804	Element #1 Residents #9 and #116 have been queried regarding food palatability, likes/dislikes, preferred food temperatures, and satisfaction with meals. Element #2 Residents currently residing in facility have the potential to be affected by cited practice. Interview able like residents have been queried regarding satisfaction with meals. Element #3 The policy on Trayline Food Temperatures has been reviewed and deemed appropriate. Dietary staff have been educated on the Trayline Food Temperature policy to ensure residents are being served palatable food at preferred temperatures. Element #4 Dietary Manager or designee will conduct 5 random resident audits 5x's per week x 4 weeks then 2x's per week x 4 weeks, then monthly for 2 months to ensure food served is palatable and at preferred temperature. Deficiencies will be immediately corrected. Results of audits will be submitted to facility's monthly Quality Assurance Committee for review and further recommendations until substantial compliance is achieved and maintained. The Dietary Manager is responsible for continued monitoring and compliance. The Administrator is responsible for ongoing compliance with regulatory requirements.	12/29/2023

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	food on their plate and stated, "The french fries are cold and hard as a rock." On 12/5/23 at 12:32 PM, a random food tray selected off of the food cart on the 100 unit was temperature tested by Registered Dietician (RD) "N" and the results were the following: Grilled ham and cheese sandwich: 100 degrees Fahrenheit. Other items on the food tray included coffee, whole milk, and canned peaches. RD "N" was interviewed and asked what temperature they would prefer for the sandwich. RD "N" stated, "It's like toast, it's hard to keep warm." RD "N" was further questioned about the desired temperature for the sandwich and stated, "I like it to be above 100 degrees Fahrenheit." RD "N" was requested to taste the sandwich, which they did, and indicated that the sandwich tasted, "Okay." On 12/5/23 at 12:37 PM, the grilled ham and cheese sandwich was taste tested by the surveyor and the results revealed that the sandwich was tepid which negatively impacted the taste. On 12/5/23 at 12:53 PM, a review of R9's electronic medical record (EMR) revealed that R19 was admitted to the facility on 7/9/22 with diagnoses that included Type 2 diabetes and Major depressive disorder. R19's most recent minimum data set assessment (MDS) dated 9/29/23 revealed that R9 had an intact cognition.			

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	On 12/5/23 at 12:58 PM, a review of R116's EMR revealed that R116 was admitted to the facility on 5/5/21 with diagnoses that included Dementia and Muscle weakness. R116's most recent minimum data set assessment (MDS) dated 11/10/23 revealed that R9 had a moderately impaired cognition. On 12/6/23 at 12:09 PM, the administrator (NHA) was interviewed about food palatability and food temperature at the facility and stated, "Obviously we want to get the trays down as quick as possible. We are trying to get the residents up more for meals. Since I have been here, we have been trying to get more residents in the dining room." On 12/6/23 at 1:30 PM, a facility policy titled "Trayline Food Temperature Issue Date: 6/3/2005" was reviewed and stated the following, "Policy: It is the policy of this facility to serve food at acceptable temperatures that deter bacterial growth...Procedures: 3. Hot foods...shall be held at or above 140 degrees Fahrenheit..."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §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	F0812	Deficient Practice #1 Element #1 No specific residents were identified in the cited practice. Element #2 Residents currently residing in the facility have the potential to be affected by the cited practice. Risk analysis: Dietary Manager or designee are to follow the guidelines for food storage, preparation, distribution, sanitation, and serving food in accordance with	12/29/2023

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	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: This citation has two deficient practices. Deficient practice statement #1. Based on observation, interview, and record review the facility failed to maintain sanitary conditions in the kitchen resulting in an increased potential for cross contamination of food and foodborne illness, potentially affecting 144 residents who receive meal services (7 nothing by mouth residents, or NPO) out of the facility's total census of 151 residents. Findings include: 1. On 12/5/23 between 9:45 AM, and 10:47 AM, the following non-food contact surfaces in the kitchen were observed soiled and with visible debris on their surfaces: On the doors of the cook's reach in refrigerator. On the flooring in the dry storage room. On the walls and flooring behind the juice machine.		professional standards for food service safety. Element #3 The policies for Food Storage, Outside Food, Kitchen Sanitation to Prevent the Spread of Viral Illness, and Trayline Food Temperature were reviewed and deemed appropriate. Dietary staff were educated on reviewed policies. Element #4 Dietary Manager or designee will conduct audits of cooks reach-in refrigerator, dry storage room, kitchen walls and floors, walk-in coolers, refrigerator #1, proper washing/rinsing of fruits and vegetables, proper temping of food, proper thawing/cooling and logging process of foods, staff properly washing hands and donn/doffing of gloves, and staff not storing personal belongings in kitchen areas 5x's week x4 weeks then 2x's week x 4weeks, and then monthly for 2 months. Deficiencies will be immediately corrected. Results of audits will be submitted to facility's monthly Quality Assurance Committee for review and further recommendations until substantial compliance is achieved and maintained. The Dietary Manager is responsible for continued monitoring and compliance. The Administrator is responsible for ongoing compliance with regulatory requirements. Date of completion: 12/29/23 Deficient Practice #2 Element #1 No specific residents were identified in the cited practice. Element #2 Residents currently residing in the facility have the potential to be affected by the cited practice. Items observed with no dates and/or names in the Winter Unit Medication resident refrigerator were immediately removed and	

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	On the floor of the walk-in cooler and its shelving. On the lower interior portion of refrigerator #1. On the flooring throughout the kitchen. On 12/5/23 at 10:50 AM, upon interview with Dietary Manager, staff A, on if the facility keeps daily cleaning logs for tasks to be completed to which they replied, "Yes. We have sign off sheets for our daily cleaning tasks. I can email them to you". On 12/6/23 at 8:42 AM, record review of a document titled, "Routine cleaning and disinfection" dated 8/ 2022, revealed a system in place to ensure a clean and sanitary environment in the kitchen. At the time of the survey team's exit, no additional cleaning schedule documenting verification of the daily cleaning tasks required to be completed was received to review. Review of 2017 U.S. Public Health Service Food Code, Chapter 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, directs that: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.		discarded. Resident refrigerators in the Medication Rooms on the Autumn, Summer, and Spring units were audited for properly labeled/dated items. Element #3 The policy on “Outside Food” was reviewed and deemed appropriate. Licensed Nursing Staff were educated the “Outside Food” policy with focusing on labeling and dating all resident food items they place in the Resident refrigerators in the Medication Rooms. Element #4 The Unit Managers or designee will conduct audits of each Medication Room Resident refrigerator 3x’s week x 4 weeks, the 1x week x 4weeks, then 1 time a month for 2 months. Deficiencies will be immediately corrected. Results of audits will be submitted to facility’s monthly Quality Assurance Committee for review and further recommendations until substantial compliance is achieved and maintained. The Unit Managers are responsible for continued monitoring and compliance. The Director of Nursing is responsible for ongoing compliance with regulatory requirements.	

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	2. On 12/5/23 at 10:57 AM, at 11:23 AM, and at 11:49 AM, the lack of hand washing was observed as Dietary Manager, staff B, was observed not washing their hands prior to donning gloves while conducting meal preparation tasks for the ham and cheese sandwiches served for the days lunch. On 12/5/23 at 11:43 AM, Dietary aide, staff C, was observed removing their gloves after handling dirty dishes and without washing their hands began handling clean dishes and utensils. On 12/5/23 at 12:27 PM, Dietary aide, staff D, was observed donning gloves prior to washing their hands while handling refrigerator door handles, touching their face, cambro lids, vegetables, a cutting board, and two food preparation counters. On 12/5/23 at 12:16 AM, and at 12:23 AM, Cook, staff F, was observed not washing their hands between removing and donning gloves while conducting food preparation. On 12/5/23 at 12:03 PM, Cook, staff E, was observed donning gloves after touching food trays, prep counters, the steam table, thermometers, and their clothing prior to handwashing. On 12/5/23 at 11:40 AM, upon interview with Dietary Manager, staff A, the surveyor inquired the hand hygiene expectations for staff when they choose to use gloves as a hand barrier to which they replied, "wash their hands before they put them on". At this time the surveyor inquired if they could email a copy of the facility's glove use policy to			

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	which they replied, "sure, I will get it emailed to you". On 12/6/23 at 10:04 AM, record review of a document entitled, "Kitchen Sanitization to Prevent the Spread of Viral Illness" dated 2/2023 revealed the requirement that, "When using gloves, always wash hands before touching or putting on new gloves". Review of the U.S. Public Health Service 2013 Food Code, Chapter 2-301.14 When to Wash directs that: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLEUSE ARTICLES and: and contamination and to prevent cross contamination when changing tasks; (H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands. 3. On 12/5/23 at 11:43 AM, Cook, staff E, was observed plating meals from the steam well for the days lunch service. At this time the surveyor inquired with staff E if they had the opportunity to take temperatures prior to			

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	serving to which they replied, "no, we just take them out of the oven and put them in the steam well". On 12/5/23 at 11:44 AM, the surveyor asked staff E if they wouldn't mind taking temperatures before plating the next meal to verify the foods proper holding temperatures to which they replied, "sure". On 12/5/23 at 11:47 AM, staff E began taking temperatures of food products in the steam well via a thermometer probe revealing a temperature of 124 degrees F for the Ham and cheese sandwiches. At this time the surveyor asked staff E what they would normally do in a situation like this to which they replied, "I'm not sure what you mean". Upon overhearing this, Dietary Manager, staff A, stated, "we need to pull it and reheat it on the stove to 165 degrees F before we can serve any more of it. Let the staff know they will have to wait a minute". At this time staff A asked Dietary Manager, staff B, what there final cooking temperature was on this tray to which they replied, "I don't know, I just took them off the cook top and placed them in the hot holding cart". On 12/5/23 at 11:51 AM, upon record review by the surveyor and staff A of the kitchen's temperature log, the final cooking temperature of the sandwiches revealed no temperature had been recorded, along with all the other foods for the days lunch and breakfast. At this time staff A told staff E and staff B to, "throw out that tray of sandwiches. We need to make new. You know we need to take our temps". Review of 2013 U.S. Public Health Service			

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	Food Code, Chapter 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding directs that: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5ºC (41ºF) or less. P 4. On 12/5/23 between 10:22AM, and 10:58 AM, the following storage observations were made in the kitchen: An employee beverage was observed on a prep table touching a ham and cheese sandwich. An employee beverage was observed on a shelf above the steam table serving line. A N-95 mask was observed on a shelf above the steam table serving line. A pair of eyeglasses were observed stored above ham and cheese sandwiches and next to food ingredients.			

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	A cellphone was observed stored above ham and cheese sandwiches and next to food ingredients. A cell phone was observed stored next to cans of food in the dry goods storage room. An opened energy drink and an unlabeled Tupperware container were observed stored over and next to food items in refrigerator #1. On 12/5/23 at 10:59 AM, upon interview with Dietary Manager, staff A, on what their expectations are for the storage of these items at the facility they stated, "they should have masks on their faces, and cell phone should not be out in the kitchen. They have lockers and a break area that they aren't using, I will get our policy". On 12/6/23 at 9:49 AM, review of documents in an email entitled, "Kitchen Sanitization to Prevent the Spread of Viral Illness" dated 2/2023 revealed that the facility has a policy in place to ensure that employee personal belongings are stored in designated storage areas only". Review of 2017 U.S. Public Health Service Food Code, Chapter 6-403.11 Designated Areas directs that: (A) Areas designated for EMPLOYEES to eat, drink, and use tobacco shall be located so that FOOD, EQUIPMENT, LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES			

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	are protected from contamination. 5. On 12/5/23 at 1:05 PM, Dietary aide, staff D was observed unwrapping a head of lettuce, placing it on a cutting board and cutting it in half. On 12/5/23 at 1:06 PM, upon observation the surveyor inquired with staff D if the facility has any fruits or vegetables that are pre-washed to which they replied, "No. I was just getting ready to wash it". On 12/5/23 at 1:09 PM, staff D was observed unpacking grape tomatoes, placing them on the same cutting board and cutting them in half without rinsing them off first prior to placing them in salad bowls. 12/5/23 at 1:13 PM, staff D was observed placing cucumbers on the same cutting board and cutting them without rinsing them off first prior to placing them in salad bowls. Review of 2017 U.S. Public Health Service Food Code, Chapter 3-302.15 Washing Fruits and Vegetables, directs that: (A) Except as specified in (B) of this section and except for whole, raw fruits and vegetables that are intended for washing by the CONSUMER before consumption, raw fruits and vegetables shall be thoroughly washed in water to remove soil and other contaminants before being cut, combined with other ingredients, cooked, served, or offered for human consumption in READY-TO-EAT form. 6. On 12/5/23 at 11:31 AM, a container with a			

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	label stating "Hamberger" and a container with a label stating "Mash potatoes" with the dates of 12/4/23 - 12/6/23 on their lids were observed in the cook's reach-in refrigerator. At this time, upon interview with Dietary Manager, staff A, on if the facility prepares food products in advance and then cools them down for later use, they replied, "sometimes". On 12/5/23 at 11:33 PM, the surveyor inquired with staff A on if the facility keeps cooling logs for the items they cool down for later use to which they replied, "no, we don't have a log". At this time the surveyor then followed up by asking staff A how the facility would normally handle food items such as these if they could not verify the foods were properly cooled to ensure the foods safety to which they replied, "I see your point, I guess we will need to start using a cooling log and throw things out if we don't". Review of U.S. Public Health Service 2017 Food Code, Chapter 3-501.15 Cooling Methods, directs that: (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under § 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; Pf (2) Separating the FOOD into smaller or thinner portions; Pf			

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	(3) Using rapid cooling EQUIPMENT; Pf (4) Stirring the FOOD in a container placed in an ice water bath; Pf (5) Using containers that facilitate heat transfer; Pf (6) Adding ice as an ingredient; Pf or (7) Other effective methods. On 12/04/23 at 9:05 AM, during the initial kitchen tour the meat slicer was observed to have a significant amount of old residual meat hung up on the blade and laying on other parts of the slicer as well as around it on the base table. The facility Dietary Manager (CDM) reported that the slicer had not been cleaned from the previous evening. On 12/06/23 at 12:34 PM, the CDM reported that, regarding the soiled meat slicer observed during the initial kitchen tour, the expectation is that the slicer would be cleaned after the current use is completed and by the end of the shift of its use at the latest. Review of the facility policy titled "Kitchen Sanitation to Prevent the Spread of Viral Illness" dated 02/21/23 revealed the "Guidelines" item: "6. All other food contact surfaces and equipment shall be washed, rinsed and			

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	sanitized per USDA Food Code recommendations". Review of the FDA Poster Document "Keep Commercial Deli Slicers Safe" revealed the instruction statement "Clean and sanitize deli slicers per manufacturer's instructions at least once every four hours in order to prevent the growth of disease-causing bacteria". Deficient practice statement #2. Based on observation and record review, the facility failed to ensure proper label and dating of food brought from outside the facility for residents residing on the Winter unit, resulting in the increased potential for foodborne illness. This deficient practice has the potential to affect all residents that store food in the resident refrigerator. Findings Include: On 12/5/2023 at 9:03 AM, an observation of the Winter unit medication room was completed. Upon inspection of the resident freezer, three bags of frozen food were observed. A name and room number were observed on one bag of frozen food, no date. No name or date were observed on the other two bags. All three bags were noted to be opened. On 12/5/2023 at 9:06 AM, an interview was conducted with Unit Manager (UM) "Q". UM "Q" was shown the undated and unlabeled items. UM "Q" stated that the items should			

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	have been labeled and dated and took the items out of the freezer. On 12/6/2023 at 11:54 AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was queried regarding their protocol for outside food. The NHA stated that any food brought from outside should be labeled with the resident's name and dated. The NHA stated that it should be discarded within 48-72 hours. A review of a facility policy titled, "Outside Food Policy" noted the following, "When families bring in food for our residents, the facility will provide safe storage as defined by the FDA Code. All food items provided by families will be labeled and dated, stored properly, and used within an acceptable timeframe."			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and	F0880	F-880- Infection Prevention and Control Element #1 A total of 9 residents who tested positive for Covid-19 during the evening shift on 12/3/23 were moved to a designated Covid-19 hallway on 12/5/23. 1 resident no longer resides in the facility. The other 8 residents continue to reside in the facility and have recovered from Covid-19. Additional residents that tested positive for Covid-19 were moved to the designated Covid-19 hallway per facility protocol and CDC recommendations. All residents who were exposed to previously Covid-19 positive roommates continued to test negative for Covid-19. Transmission Based Precautions Signs were immediately	12/29/2023

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	824350	A. BUILDING _____ B. WING _____	**12/6/2023**

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	other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:		posted on all residents rooms and physicians orders reflected TBP status were entered. PPE supplies were provided and re-supplied as needed in the designated Covid-19 hallway. Education on Covid-19 precautions including PPE use was immediately initiated upon discovery of the identified practice. Element #2 All residents who reside in the facility have the potential to be impacted by the identified practice. The facility initiated covid-19 testing per the recommendations of the local health department which followed the recommendations of the CDC. Element #3 The facility Covid-19 Policy was reviewed and deemed to be appropriate for education. All staff were re-educated on the Covid-19 Policy. Element #4 The Infection Preventionist/Designee will audit residents who test positive for Covid-19 to ensure prompt transfer of the residents to the designated Covid-19 hallway, ensure separation from a roommate who tests negative for Covid-19, ensure TBP orders and signage are in place, and to ensure PPE supplies are available for staff and visitors to use per the Covid-19 policy. The audit will occur 3x/week x4 weeks, then monthly x2 months. Deficiencies will be immediately corrected. Findings will be submitted to the QAPI committee for further review and recommendations until substantial compliance is achieved and maintained. The DON is responsible for substantial compliance.	

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	Based on observation, interview, and record review, the facility failed to midigate the spread of COVID-19 per facility policy, and the Centers for Disease Control (CDC) guidance resulting in the potential of transmission of infectious disease, and the development of new or recurring infections potentially affecting all 151 residents residing in the facility. Findings include: R92 On 12/4/23 at 10:21 AM, during an initial tour of the facility a transmission based precautions (TBP) sign was observed on the door of R92's room. The sign indicated that any person entering the room should don (put on) proper personal protection equipment (PPE) which included gown, gloves, N95 mask (Filtering mask), and face shield. Observation and inspection of the infection control cart located next to R92's room revealed an absence of sanitary bleach wipes, N95 masks, and gloves. On 12/4/23 at 10:24 AM, R92 was interviewed in their room and asked why they were on TBP. R92 responded, "I tested positive for COVID-19 on Sunday (12/3/23)." R92 indicated that they were feeling well other than "being tired". During the surveyor's interview with R92 it was observed that R16 was present in the bed next to R92. R16 was asked about their COVID-19 status and responded, "I don't have COVID-19."			

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	On 12/6/23 at 2:12 PM, a review of a progress note located in R92's electronic medical record (EMR) indicated the following, "12/3/2023 10:40: Nursing - Progress Note Text: Resident complaining of loss of appetite, sore throat, lungs burning, stuffy nose, and vomiting. Resident didn't eat breakfast; MD (Medical Doctor) was notified new orders were given and put in place. Resident did test positive for Covid. MD also stated if resident starts to feel SOB (Short of breath)...to send resident out to the hospital". R57 On 12/4/23 at 9:40 AM during the inital tour of facility, R57 was observed lying in the bed in their room. When asked R57 if they had any concerns, R57 replied, "My roommate has COVID but I have not tested positive yet." Upon observation, there was a sign on the door and a container outside the door with masks and some personal protection equipment. On 12/5/23 at 11:00 AM, R57 stated to surveyor, "My roommate has been moved to another room". R139 On 12/4/23 at 9:25 AM during the inital introduction to residents, R139 was observed lying in the bed in their room. R139 was asked, "How are you feeling today?" R139 replied, "Not well, I found out that I had			

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	COVID-19 yesterday." Upon observation there were no signs indicating that Transmission Based precaution measures were needed nor any personal protection equipment available outside of the door. On 12/5/23 at 11:00 AM, R139 was observed being moved to another room on another unit. On 12/4/23 at 9:30 AM, an initial tour of the Summer unit was conducted, with one room being identified as having signage on the door, identifying that the resident in the room was on transmission-based precautions (TBP). There were no other rooms on the unit observed with signage. On 12/4/23 at 12:05 PM, a second room, room 216 on the Summer unit was observed with signage on the closed door indicating that the resident in that room was on TBP. On 12/4/23 at1:40 PM, room 216 was observed now with the door open, and no TBP sign was observed on the door. A visitor was observed inside the room without a mask covering their nose and mouth. A staff member was observed entering and exiting the room wearing only a surgical mask. On 12/4/23 at 3:14 PM, room 216 was observed to have TBP signage back up on the closed door of the room. On 12/5/23 at 10:02 AM, the Infection			

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	Control Preventionist (ICP "R") was interviewed regarding the number of COVID positive residents within the facility, and she explained that the facility had tested and identified 8 residents on 12/3/23 that had tested positive for COVID-19. In addition, one other resident tested positive for COVID-19 on 12/5/23, and five staff members were currently out sick for testing positive as well. The ICP further explained that on 12/3/23, two residents were located on the Summer unit, while the other six were identified on the Spring Unit. ICP "R" was asked why the COVID-19 positive residents remained in their rooms with their roommates that had tested negative for COVID-19 when there were open beds available in the facility. ICP "R" explained that the Director of Nursing (DON) advised her to keep the residents in their respective rooms, as they had already been exposed to COVID-19. ICP "R" was asked about the observation of room 216, and she explained that there was confusion regarding the resident's COVID status, but ultimately the confusion was resolved, and the resident is now on TBP for testing positive for COVID-19. ICP "R" was asked for her expectation regarding staff entering TBP rooms, and she explained that staff are supposed to wear an N-95 mask, a face shield, gown, and gloves. On 12/5/23 at 11:10 AM, the DON approached the surveyor and explained his rationale for cohorting positive COVID-19			

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	residents with negative residents. The DON explained that he wanted the residents that had been exposed to "shelter in place" in an effort to lessen the exposure to other residents on a unit that had less COVID positive residents. On 12/5/23 at 12:00 PM, ICP "R" and DON approached surveyor and explained that they would be moving the COVID-19 positive residents out of the rooms with the residents that were negative for COVID-19. On 12/6/23 at 11:54 AM, the Nursing Home Administrator was asked about the infection control concerns within the facility, and explained that they would be soliciting assistance from another State agency to review their infection control program. A review of the total number of COVID-19 positive residents by the end of this survey was 10 residents, and there was a total of eight other exposed residents. A review of the facility's "COVID-19" policy revealed the following, "Placement of residents with suspected or confirmed Covid-19: · Ideally, residents should be placed in a single-person room with the door closed. · If limited single rooms are available or if numerous residents are simultaneously identified to have knownCovid-19 exposures			

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	or symptoms concerning for Covid-19, residents should remain in their current location. · Residents with confirmed Covid-19 infection should only be cohorted with other residents who have a confirmed Covid-19 infection..." A review of the Centers for Disease Control (CDC) at www.cdc.gov, Last Reviewed: November 14, 2023 revealed the following, "...Placement Decisions A) Residents confirmed to have SARS-CoV-2 infection should be placed in a single room, if available, or housed with other residents with only SARS-CoV-2 infection. If unable to move a resident, he or she could remain in the current room with measures in place to reduce transmission to roommates (e.g., optimizing ventilation). Residents found to have SARS-CoV-2 and influenza virus co-infection should be placed in a single room or housed with other co-infected residents. These residents should continue to be cared for using all recommended PPE for the care of a resident with SARS-CoV-2 infection..."			