STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495403	A. BUILDING _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/20/23 through 06/23/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 06/20/23 through 06/23/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey. VA00052626 = substantiated with no deficiency VA00052491 = unsubstantiated VA00052167 = unsubstantiated The census in this 96 certified bed facility was 84 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must--	F 577		7/20/23

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

Electronically Signed | 07/11/2023

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F 577	Continued From page 1 (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to make the results of their most recent survey conducted by Federal or State surveyors accessible for residents, family members, and legal representatives of residents to review. This failure had the potential to affect all 84 residents who resided in the facility. Findings include: A group interview was conducted on 06/21/23 at 1:30 PM with eleven residents whom the facility identified as reliable historians. During the meeting, eleven of the eleven residents (Resident (R)5, R7, R19, R30, R32, R41, R51, R54, R58, R190, and R191) who participated were unaware where the facility's previous survey results conducted by Federal and State surveyors could be located and reviewed in the facility. An observation on 06/21/23 from 3:15 PM to 3:45 PM of the facility's first, second, and third floors	F 577	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. Residents R5, R7, R19, R30, R32, R41, R51, R54, R58, R190, and R191 have been informed as to where the survey results can be found. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a. All residents in facility have potential to be affected. b. All residents/RRs will be informed by letter from facility with instructions on how to access the survey results without having to ask a staff member. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; a. Facility has mounted survey results	

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F 577	Continued From page 2 revealed the facility's previous survey results could not be located and there was no posted information which notified residents, family members, and legal representatives of residents where the facility's previous survey results could be located and reviewed without having to ask a staff member. An observation on 06/23/23 from 12:15 PM to 12:35 PM of the facility's first, second, and third floors, with the Administrator, revealed the facility's previous survey results could not be located in the facility. Additionally, no posted information was observed in the facility which notified residents, family members, and legal representatives of residents where the survey results could be located and reviewed without having to ask a staff member. During an interview on 06/23/23 at 12:35 PM, the Administrator confirmed the facility's prior survey results could not be located in the facility at this time and he would ask staff to continue to try to find them. The Administrator stated the facility's prior survey results were previously placed in a notebook and kept on the first floor for review. Since the facility's first floor was currently undergoing construction a staff member may have moved the survey results notebook to a different location. During an interview on 06/23/23 at 12:50 PM, the facility's Assistant Director of Nursing (ADON), stated she found the notebook which contained the facility's prior survey results. The ADON stated the notebook was found on a shelf on the facility's third floor.	F 577	directly outside of elevators on the second and third floor, which is the primary access to the healthcare facility and highly visible to all who enter and exit. b. Mounting was completed at wheelchair height to ensure access to all residents/resident representatives (RR)s. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. a. Medical Records clerk or designee will inspect x1/week for x4 weeks to ensure survey book is complete (past 3 years of surveys) still mounted correctly and visible. b. Thereafter Medical Records clerk or designee will then round x1/month for x3 months to ensure survey book is complete (past 3 years of surveys), still mounted correctly and visible. c. Once a zero % error rate has been observed for x3 months the audit will be discontinued. d. Variances will be investigated, corrected as appropriate and feedback and re-education and/or counseling will be provided to the responsible team members. Results/findings of the audits will be reviewed and discussed at the next scheduled QAPI meeting for continued review and oversight 5. Include dates when the corrective action will be completed. (The outside date by which all corrections must be made is the 45th calendar day after the survey ended.) a. Date of compliance: 07/20/23	
F 658 SS=D	Services Provided Meet Professional Standards	F 658		7/20/23

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F 658	Continued From page 3 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide services as outlined in the comprehensive care plan that meet professional standards of quality for 1 Resident (#50) in a survey sample of 33 Residents. The findings included: For Resident #50 the facility staff failed to accurately transcribe the Registered Dietician and the Wound Care Physician's orders. On 6/21/23 a review of the clinical record of Resident #50 was conducted. Excerpts from the dietician notes are as follows: "12/20/22 at 1:18 PM - Sig change for new wound. Please refer to [Registered Dietician name redacted] regarding new wound. Prostat was added daily x 4 weeks. Recommend adding zinc and vitamin c for healing as well." Resident # 50 was seen by the wound specialist on 12/21/23 who made the following notes: "Recommendations: Off-load wound. Reposition per facility protocol. Group 2 mattress; Gel cushion to chair, incontinence protocol with brief check and house barrier ointment applies q shift and prn. Vitamin C 500 mg twice daily, Zinc	F 658	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. As of 03/16/23, R50's orders were corrected. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a. All transcribed orders were reviewed and are accurate as of 06/23/23. Moving forward, all transcribed orders for the previous day will be audited for accuracy by Director of Nursing (DON) or designee. b. Variances will be investigated, corrected as appropriate and feedback and re-education and/or counseling will be provided to the responsible team members. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; a. All transcribed orders will be audited daily for accuracy by DON or designee. b. Variances will be investigated, corrected as appropriate and feedback and re-education and/or counseling will be provided to the responsible team members.	

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F 658	Continued From page 4 sulphate 220 mg PO daily for 14 days. On 12/21/22 the following orders were put in INCORRECTLY. "Vitamin C 500 mg tablet (Ascorbic acid) -500 mg by mouth every day for wound healing. stop date 1/21/23" [The order should have been twice daily] "Zinc 50 mg by mouth every day for wound healing stop date 1/21/23" [The order should have been 220 mg.] "Prostat 30 ml po q day to supplement X 4 weeks. stop date 12/29/23." [The stop date should have been 1/26/23] On 6/22/23 at approximately 11:00 AM an interview was conducted with Employee J who stated that she had seen the wound and made recommendations to the dietician and the wound care specialist. The error was in the transcription of the orders from the dietician and the wound care specialist regarding the Prostat and the Vitamin C and Zinc orders. The orders were later corrected on 3/16/23 and the appropriate vitamins and supplements were given in the correct amounts. According to the website for the National Institutes of Health following the 5 Rights of Medication Administration can aid in avoiding medication errors. The National Institutes of health website - https://www.ncbi.nlm.nih.gov/books/NBK560654/ 'Right patient' - ascertaining that a patient being treated is, in fact, the correct recipient for whom medication was prescribed. 'Right drug' - ensuring that the medication to be administered is identical to the drug name that was prescribed.	F 658	c. Education will be provided to the nursing team regarding process and best practices for transcribing orders accurately. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; a. DON or designee will audit all transcribed orders once a week for x4 weeks to ensure that orders are transcribed correctly. b. Thereafter, DON or designee will audit all transcribed orders once per month for x3 months to ensure that orders are transcribed correctly. c. Once a zero % error rate has been observed for x3 months, the audit will be discontinued. d. Variances will be investigated, corrected as appropriate and feedback and re-education and/or counseling will be provided to the responsible team members. Results/findings of the audits will be reviewed and discussed at the next scheduled QAPI meeting for continued review and oversight 5. Include dates when the corrective action will be completed. (The “outside” date by which all corrections must be made is the 45th calendar day after the survey ended.) a. 07/20/23	

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F 658	Continued From page 5 'Right Route' - Medications can be given to patients in many different ways, all of which vary in the time it takes to absorb the chemical, time it takes for the drug to act, and potential side-effects based on the mode of administration. 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. 'Right dose' - Incorrect dosage, conversion of units, and incorrect substance concentration are prevalent modalities of medication administration error. On 6/23/23 during the end of day meeting, the Administrator was made aware and no further information was provided.	F 658		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		7/20/23

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F 812	Continued From page 6 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to keep the kitchen's ice machine, electric mixer, manual can opener, food preparation pans, and a kitchen drawer which housed food preparation equipment clean; failed to cover and date stored foods; and keep the second-floor service kitchen's ice machine clean. This failure had the potential to affect all 84 residents who consumed food prepared from the facility's kitchen. Findings include: Review of the facility's policy titled, "Sanitation," dated 01/01/23, revealed, "Policy: The food service area shall be maintained in a clean and sanitary manner. . . . 2. All utensils, counters, shelves, and equipment shall be kept clean and maintained in good repair . . .12. Ice machines and ice storage containers will be drained, cleaned, and sanitized per manufacturer's instructions and facility policy." Review of the facility's policy titled, "Food Receiving and Storage," dated 01/01/23, revealed, "All foods stored in refrigeration or freezer will be covered, labeled, and dated ("use by" date)." 1. Observation during the initial kitchen inspection on 06/20/23 from 12:35 PM to 1:05 PM, with the facility's Administrator present, revealed the following unclean stored and ready for use food preparation equipment:	F 812	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; a. As of 06/23/23, the following items were corrected and now in compliance with facility policy. i. The interiors of all ice machines (main kitchen, second floor pantry, and third floor pantry) were cleaned to standard with no residual brown and pink colored substance noted upon inspection by Dining Services Director (DSD). ii. The kitchen's large electric mixer was cleaned to standard with no residual dried food substances on the mixer's metal guard, underside of the mixer's head, or the mixer's base noted upon inspection by DSD. iii. All kitchen drawers were cleaned to standard with no residual food debris and/or crumbs noted upon inspection by DSD. iv. The kitchen's manual can opener was detached from the food preparation table and cleaned to standard. No residual sticky substances were noted on its blade and/or metal table base attachment upon inspection by DSD. v. All food preparation pans were audited for moisture and residual food debris on their interior surface. No noted moisture and/or food debris was noted upon inspection by DSD. vi. Large bag of hush puppies and large	

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F 812	Continued From page 7 a. The interior of the kitchen's large ice machine had brown and pink colored substance that could be wiped away with a paper towel. b. The kitchen's large electric mixer had dried food substances on the mixer's metal guard, underside of the mixer's head and the mixer's base. c. A kitchen drawer, with food preparation equipment stored inside had food debris and crumbs. d. The kitchen's manual can opener was attached to a food preparation table had accumulated sticky substances on its blade and metal table base attachment. e. Eight of 10 food preparation pans, stacked tightly together and ready for use, had accumulated moisture on their interior surface. Three of these pans had food residues on their interior surface. During an interview on 06/20/23 at 1:05 PM, the Administrator confirmed the kitchen's ice maker, electric mixer, manual can opener, food preparation pans and a drawer housing food preparation equipment were not clean. The Administrator stated food preparation equipment should be kept clean by staff. 2. Observation during the initial kitchen inspection on 06/20/23 from 12:35 PM to 1:05 PM, with the Administrator present, revealed the following concerns with food storage: a. Observation of food stored in the kitchen's walk-in freezer revealed a large bag of hush	F 812	bag of potato crisps that were observed stored incorrectly were discarded. Audit was performed by DSD and all items in walk-in freezer were in compliance with facility policy. vii. The following items observed stored incorrectly were discarded: gallon container of mayonnaise, gallon container of light raspberry dressing, gallon of poppy seed dressing, and gallon of cocktail sauce. Audit was performed by DSD and all items in walk-in refrigerator were in compliance with facility policy. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; a. All residents have potential to be affected by deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; a. DSD or designee will provide education to all food service staff regarding facility policy and procedure on Sanitation, Food Receiving and Storage, cleaning schedules, and expectations/standards. b. DSD or designee will complete an audit of the following areas for compliance to ensure cleanliness and compliance with facility policy. i. Ice machines located in main kitchen and facility pantries; ii. All drawers within main kitchen; iii. Main kitchen□s manual can opener; iv. All food preparation pans; v. Correct coverage, labels, and dating for all items in walk-in refrigerator and	

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F 812	Continued From page 8 puppies and a large bag of potato crisps were stored opened. b. Observation of food stored in the kitchen's walk-in refrigerator revealed the following previously opened foods were not dated: a gallon container of mayonnaise, a gallon container of light raspberry dressing, a gallon container of poppy seed dressing and a gallon container of cocktail sauce. During an interview on 06/20/23 at 1:05 PM, the Administrator stated food should be dated when opened and completely closed when stored by staff. 3. Observation of the second-floor service kitchen, with the Dining Service Manager (DSM) present, on 06/22/23 at 12:10 PM revealed the interior of the kitchen's ice machine had black colored substance. The black colored substance could be wiped away with a paper towel. During an interview on 06/22/23 at 12:10 PM, the DSM stated the second-floor kitchen's ice machine should be kept clean by staff.	F 812	walk-in freezer in main kitchen. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; a. DSD or designee will audit the following areas for compliance x1 per week for x4 weeks to ensure cleanliness and compliance with facility policy. i. Ice machines located in main kitchen and facility pantries; ii. All drawers within main kitchen; iii. Main kitchen□s manual can opener; iv. All food preparation pans; v. Correct coverage, labels, and dating for all items in walk-in refrigerator and walk-in freezer in main kitchen. b. Thereafter, DSD or designee will audit the following areas x1 per month for x3 months to ensure cleanliness and compliance with facility policy. i. Ice machines located in main kitchen and facility pantries; ii. All drawers within main kitchen; iii. Main kitchen□s manual can opener; iv. All food preparation pans; v. Correct coverage, labels, and dating for all items in walk-in refrigerator and walk-in freezer in main kitchen. c. Once a zero % error rate has been observed for x3 months, the audit will be discontinued. i. Variances will be investigated, corrected as appropriate and feedback and re-education and/or counseling will be provided to the responsible team members. Results/findings of the audits will be reviewed and discussed at the next scheduled QAPI meeting for continued review and oversight	

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F 812	Continued From page 9	F 812	d. Include dates when the corrective action will be completed. (The outside date by which all corrections must be made is the 45th calendar day after the survey ended.) i. 07/20/23	