STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 08/20/2021 The following deficiencies relate to the facility's annual health survey and investigation of complaints #96923-C, #96475-C, #95033-C and JS / #98669-C completed 7/19/21-7/28/21. Complaint #96923 was not substantiated. Complaint #98669 was substantiated. Complaint #96475 was substantiated. Complaint #95033 was not substaniated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000	Submission of the response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Executive Director, or other associates, agents, or other individuals who draft or may be discussed in this response and plan of correction. Preparation and submission of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any fact alleged or the correctness of any conclusion set forth in these allegations by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of appeal of these matters solely because of the requirements under State and Federal law that mandate submission of a plan of correction within ten (10) days of the receipt of survey findings, as a condition to participate in the Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admission by the facility.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to place the resident's call light within reach for 1 of 19 residents,(Resident #21). The facility reported a census of 55. Findings include: The Minimum Data Set (MDS) dated 5/28/21 revealed Resident #21 could not complete a Brief Interview for Mental Status (BIMS). Not being able to complete a BIMS means the	F 558	**F 558 Reasonable Accommodations Needs/Preferences** **On 7/29/2021 Education was provided by Director of Nursing, to nursing staff on the expectation that call lights are to be within reach when resident is their room.** Tag # F558 Reasonable Accommodations Needs/Preferences **1. Immediate action(s) taken for the resident(s) found to have been affected include:** A review of Resident #21 care plan for safety interventions was completed on 8-18-2021, an assessment of resident's ability to use the call light was assessed on 8-18-2021 **2.. Identification of other residents having the potential to be affected was accomplished by:** A walk through was completed on 8-9-2021 by the maintenance director to ensure call lights were in reach while residents were in their room. The function of the call lights was checked at this time, and all were determined to be functioning properly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vanessa Young — TITLE: Administrator — (X6) DATE: 08/20/2021

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

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F 558	Continued From page 1 resident is cognitively impaired. The MDS revealed Resident #21 is dependent on one staff for locomotion in her room and in hallways and dependent on staff for cares. Review of Resident #21's Care Plan revised on 5/28/21 revealed under the focus area, resident is a risk for falls, stated the resident's call light is to be within reach and encourage the resident to use it for assistance as needed. Observation on 7/20/21 at 9:00 AM Resident #21 had her call light out of reach. The call light was on the bed while she was sitting in her wheelchair. Observation on 7/20/21 at 2:19 PM Resident #21 was in bed with call light behind her head, on the rail, and out of reach. Observation on 7/21/21 at 9:02 AM Resident #21 had her call light on the bed rail out of reach behind her. Resident #21 was located in her wheelchair next to the bed. During an interview on 7/21/21 at 1:20 PM the Director of Nursing (DON) stated the expectation is call lights are in reach when a resident is in their room.	F 558	3. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Staff were educated by Marsha James, DON on safety interventions and the importance of following items noted on the plan of care on 07/29/2021. DON instituted a staff assignment sheet to ensure staff were assigned to specific rooms/call lights daily. 4. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Administrator or designee will complete and audit of random residents at different times per day to ensure call lights are in within reach 5 x's weekly x 2 weeks, 3x's weekly x 2 weeks, then weekly x 4 weeks. Administrator or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/20/2021.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582	Tag # F582 Medicaid/Medicare Coverage/Liability Notice 1. **Immediate action(s) taken for the resident(s) found to have been affected include:** Resident #15 remains at current level of care at this time, no further action required. 2. **Identification of other residents having the potential to be affected was accomplished by:** A review of Medicare A and Medicare B discharged from skilled level of care in the last 30 days was completed on 8-18-2021, all ABN/NOMNC's were noted to be on file.	

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F 582	Continued From page 2 nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due	F 582	3. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Education was completed with Social Services, Business Office Manager, and Director of Nursing by the Administrator on 7-30-2021 regarding Medicaid/Medicare Coverage and providing liability notices. 4. **How the corrective action(s) will be monitored to ensure the practice will not recur:** Administrator or designee will complete and audit of Medicare Coverage/Liability Notices to ensure they are noted to be completed and on file, 5 x's weekly x 2 weeks, then 3x's weekly x 2 weeks, then weekly x 4 weeks. Administrator or designee will bring the findings of the audits to review with the QAPI committee. Any additional audits, education, or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/20/2021.	

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F 582	Continued From page 3 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide 1 of 3 residents discharged from skilled level of care (LOC) with the required forms for Medicare Liability Notices and Beneficiary Appeals, (Resident #15). The facility reported a census of 55 residents. Findings include: Review of the clinical record revealed Resident #15 received skilled LOC 2/8/2021 thru 3/6/2021 and remained in the facility following discharge from skilled LOC. A Progress Note dated 3/8/2021 at 7:50 PM revealed an order to change to Intermediate Care Facility LOC on 3/6/202. Resident #15's clinical record lacked documentation if the facility provided the resident with the Notice of Medicare Provider non-coverage (NOMNC) CMS form #10123 or Skilled Nursing Facility Advance Beneficiary Notice of Non Coverage (SNFABN) CMS form #10055. During interview on 7/21/21 at 1:20 PM, Human Resources reported the Medicare Liability Notices and Beneficiary Appeals forms were not completed for Resident #15 prior to her last day of coverage on 3/5/21.	F 582		

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F 582	Continued From page 4 During interview on 7/22/21 at 12:52 PM, the Administrator reported it is an expectation the appropriate Medicare Liability Notices and Beneficiary Appeals forms are given to residents in a timely manner.	F 582		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636	Tag # F636 Comprehensive Assessments & Timing **1. Immediate action(s) taken for the resident(s) found to have been affected include:** **Resident #16, a review of current care plan and PASRR was completed on 8/20/2021, the care plan was updated as indicated. Residents MDS dated 5/17/21, was reviewed on 8-5-2021, a correction request was completed to reflect a level II PASRR.** **2. Identification of other residents having the potential to be affected was accomplished by:** A review of current residents PASRR's was completed on 8/20/2021, resident with a level II PASRR, their care plan was reviewed on 8/20/2021 to verify all requested items were located on the plan of care. A review of residents MDS with Level II PASRR was completed on 8/20/2021, no concerns were identified. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** **Education was completed by Erin Melby, Regional Nurse Consultant, with MDS and Social Service Designee on 8-18-2021 regarding requirements of PASRR II to be reviewed and care plan interventions to be put in place and should be reflected on the MDS.** **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON or designee will audit PASRR Level II's to ensure accurate recommendations are located on the resident's plan of care, and the MDS reflects accurate PASRR level, following each new admission x 4 weeks.	

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F 636	Continued From page 5 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility failed to complete a accurate admission Minimum Data Set that included required information for a Preadmission Screening and Resident Review (PASRR) for 1 of 12 Residents reviewed, (Resident #16). The facility reported a census of 55. Findings included:	F 636	The DON or designee will bring the audits to review with the QAPI committee. Any additional audits, education or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/20/2021.	

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F 636	Continued From page 6 The admission Minimum Data Set (MDS) assessment tool dated 5/17/21 documented Resident #16 had diagnoses that included anxiety disorder, depression, and bipolar depression. The MDS identified an answer of no to currently considered by state level II PASRR process to have serious mental illness or related condition. The resident's Care Plan updated 5/4/21 lacked a problem area that the resident's Preadmission Screening and Resident Review (PASRR) indicated she had special needs due to her diagnosis of bipolar disorder, depressive disorder and anxiety disorder. The Care Plan included alteration in mood and behaviors related to bipolar disorder and could be verbally aggressive at times and for care givers to provide opportunity for positive interaction, attention and to stop and talk with her in passing. The PASRR Notice dated 2/13/21 for Resident #16 noted short-term nursing facility approval for 120 days. The PASRR identified ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders and to evaluate ongoing need for additional behavioral health services. The PASRR expired and the facility obtained authorization for new PASRR level II dated 6/15/21 with the same required specialized services for ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders and to evaluate ongoing need for additional behavioral health services.	F 636		

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F 636	Continued From page 7 The facility policy for MDS Completion and Submission Timeframes revised 1/20 included: Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. During an interview on 7/22/21 at 9:29 AM the Regional Nurse Consultant acknowledged she would expect the MDS to be accurate, the PASRR should have been coded on the admission.	F 636		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide services according to the Preadmission Screening and Resident Review	F 644	Tag # F644 Coordination of PASRR and Assessments **1. Immediate action(s) taken for the resident(s) found to have been affected include:** **Resident #16, a review of current care plan and PASRR was completed on 8/20/2021, the care plan was updated as indicated. Residents MDS dated 5/17/21, was reviewed on 8-5-2021, a correction request was completed to reflect a level II PASRR.** **2. Identification of other residents having the potential to be affected was accomplished by:** A review of current residents PASRR's was completed on 8/20/2021, resident with a level II PASRR, their care plan was reviewed on 8/20/2021 to verify all requested items were located on the plan of care. A review of residents MDS with Level II PASRR was completed on 8/20/2021, no concerns were identified. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Education was completed by Erin Melby, Regional Nurse Consultant, with MDS and Social Service Designee on 8-18-2021 regarding requirements of PASRR II to be reviewed and care plan interventions to be put in place and should be reflected on the MDS.	

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F 644	Continued From page 8 (PASRR) for 1 of 1 residents reviewed for level II PASRR's, (Resident #16). The facility reported a census of 55. Findings include: The admission Minimum Data Set (MDS) assessment tool dated 5/17/21 documented Resident #16 had diagnoses that included anxiety disorder, depression, and bipolar depression. The MDS identified an answer of no to currently considered by state level II PASRR process to have serious mental illness or related condition. The resident's Care Plan updated 5/4/21 lacked a problem area that the resident's Preadmission Screening and Resident Review (PASRR) indicated she had special needs due to her diagnosis of bipolar disorder, depressive disorder and anxiety disorder. The Care Plan included alteration in mood and behaviors related to bipolar disorder and could be verbally aggressive at times and for care givers to provide opportunity for positive interaction, attention and to stop and talk with her in passing. The PASRR Notice dated 2/13/21 for Resident #16 noted short-term nursing facility approval for 120 days. The PASRR identified ongoing psychiatric services by a psychiatrist to evaluate response and effectiveness of psychotropic medication on target symptoms, modify medication orders and to evaluate ongoing need for additional behavioral health services. The PASRR expired and the facility obtained authorization for new PASRR level II dated 6/15/21 with the same required specialized services for ongoing psychiatric services by a psychiatrist to evaluate response and	F 644	4.. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON or designee will audit PASRR Level II's to ensure accurate recommendations are located on the resident's plan of care, and the MDS reflects accurate PASRR level, following each new admission x 4 weeks. The DON or designee will bring the audits to review with the QAPI committee. Any additional audits, education or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/20/2021.	

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F 644	Continued From page 9 effectiveness of psychotropic medication on target symptoms, modify medication orders and to evaluate ongoing need for additional behavioral health services. During an interview on 7/22/21 at 9:13 AM the Social Service Director explained he is responsible to add the specialized services on the Care Plan. He acknowledged not sure how that got over looked and will check his notes. He further explained that her transfer was hectic and not sure why it got over looked. During an interview on 7/22/21 at 9:29 AM the RegionalNurse Consultant acknowledged she would expect the MDS to be accurate with the PASRR should have been coded on the admission.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656	Tag # F656D Develop/Implement Comprehensive Care Plan **1. Immediate action(s) taken for the resident(s) found to have been affected include:** **Resident #16, a review of current care plan and PASRR was completed on 8/20/2021, the care plan was updated as indicated. Residents MDS dated 5/17/21, was reviewed on 8-5-2021, a correction request was completed to reflect a level II PASRR.** **2. Identification of other residents having the potential to be affected was accomplished by:** A review of current residents PASRR's was completed on 8/20/2021, resident with a level II PASRR, their care plan was reviewed on 8/20/2021 to verify all requested items were located on the plan of care. A review of residents MDS with Level II PASRR was completed on 8/20/2021, no concerns were identified.	

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F 656	Continued From page 10 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review and staff interviews the facility failed to complete a comprehensive Care Plan based on residents needs for 1of 12 residents reviewed, (Resident #16). The facility reported a census of 55. Findings included: The admission Minimum Data Set (MDS) assessment tool dated 5/17/21 documented Resident #16 had diagnoses that included anxiety disorder, depression, and bipolar depression. The MDS identified an answer of no to currently considered by state level II PASRR process to	F 656	3. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Education was completed by Erin Melby, Regional Nurse Consultant, with MDS and Social Service Designee on 8/20/2021 regarding requirements of PASRR II to be reviewed and care plan interventions to be put in place and should be reflected on the MDS. 4. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON or designee will audit PASRR Level II's to ensure accurate recommendations are located on the resident's plan of care, and the MDS reflects accurate PASRR level, following each new admission x 4 weeks. The DON or designee will bring the audits to review with the QAPI committee. Any additional audits, education or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/20/2021	

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F 656	Continued From page 11 have serious mental illness or related condition. The resident's Care Plan updated 5/4/21 lacked a problem area that the resident's Preadmission Screening and Resident Review (PASRR) indicated she had special needs due to her diagnosis of bipolar disorder, depressive disorder and anxiety disorder. The Care Plan included alteration in mood and behaviors related to bipolar disorder and could be verbally aggressive at times and for care givers to provide opportunity for positive interaction, attention and to stop and talk with her in passing. The facilities policy revised 12/16 titled Care Plans, Comprehensive Person-Centered, included the policy statement. A Comprehensive, Person-centered Care Plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implement for each resident. The Policy interpretation and implementation included the following; a. The interdisciplary team in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. b. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. During an interview on 7/22/21 at 9:13 AM the Social Service Director explained he is responsible to add the specialized services on the Care Plan. He acknowledged not sure how that got over looked and will check his notes. He further explained that her transfer was hectic and not sure why it got over looked.	F 656		

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F 656	Continued From page 12 During a sequential interview on 7/22/21 at 9:49 AM the Social Service Director explained he had obtained a Level II with specialized services and he had contacted and made an appointment but did not update the Care Plan.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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: Based on observation, record review, and staff interview the facility failed to provide bathing assistance at least weekly and/or per resident preference for 2 out of 19 residents reviewed for bathing, (Resident #14 and #41). The facility reported a census of 55 residents. Findings include: 1. The Minimum Data Set (MDS) dated 5/25/21 revealed Resident #14 could not complete a Brief Interview for Mental Status (BIMS). Not being able to complete a BIMS means the resident is cognitively impaired. The MDS revealed Resident #14 is dependent on staff for cares and required total dependence for bathing. Interview with Power of Attorney (POA) on 7/20/21 at 9:50 AM stated it has been two to three weeks with no shower for Resident #14. The facility says Hospice is supposed to give the baths and Hospice states the facility is supposed to provide the shower.	F 677	Tag # F677 ADL Care Provided for Dependent Residents **1. Immediate action(s) taken for the resident(s) found to have been affected include:** **Residents #14 & #41 a review of current bath schedule was completed on 8-12-2021, bath schedule was updated on 8-12-2021, the plan of care was updated as indicated.** **2. Identification of other residents having the potential to be affected was accomplished by:** A review of current resident's bath schedules was completed on 8-12-2021, bath assignments and the plan of care were updated as indicated. A review of current resident bath documentation was completed on 8-12-2021, a bath was offered to residents who have not received a bath in the last 2 days or has requested. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Education was completed by Marsha James, DON, with staff that provide baths regarding the bath schedule, and the process for residents refusing baths on 7-29-2021. A bath aide has been assigned to increase continuity and compliance with completion of bathing task. Bathing task will be reviewed during morning clinical start up, and concerns identified will be followed up on by the Director of Nursing or Designee. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON or designee will complete an audit of bathing task 5 x;s weekly x 2 weeks, then 3x' weekly x's 2 weeks, then weekly x's 4 weeks. The DON or designee will bring the audits to review with the QAPI committee. Any additional audits, education or systemic changes will be addressed by the QAPI committee.	

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F 677	Continued From page 13 Interview on 7/21/21 at 1:14 PM the POA stated the family reached out to Hospice on Monday or Tuesday. The family stated they do not want a sponge bath and are talking to Hospice about that. Review of documentation on 7/20/21 of showers revealed bathing only occurred on 6/21/21, 6/24/21, 6/28/21 and no other showers in the past 30 days. Review of orders on 7/26/21 revealed the Doctor ordered Selsun Blue Shampoo with hair wash on shower days, one time a day on Monday, Thursday, and Friday for crust on scalp. During interview on 7/21/21 at 1:16 PM the Director of Nursing (DON) stated expects showers done by hospice staff and facility staff at least twice a week unless the resident refuses. During interview on 7/21/21 at 1:17 PM the DON stated we are working on a shower schedule and are going towards shower list with floor staff doing it. The DON expects if showers are not completed, second shift would pick them up or the showers would be completed the next day. Findings include: 2. The Minimum Data Set (MDS) assessment dated 6/30/21 for Resident #41 included diagnoses of hypertension, fracture and need for personal care. The assessment documented a BIMS score of 12 of 15 which indicated moderate cognitive impairment. The MDS indicated the	F 677	Corrective action completion date: 08/20/2021.	

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F 677	Continued From page 14 resident needed extensive assistance for bathing, personal hygiene and transferring. Review of the Care Plan revised on 3/2/20 revealed Resident #41 required assistance from staff for bathing twice a week and as necessary. During the group interview on 7/20/21 at 2:28 p.m. Resident #41 stated he had showered once in the last two weeks and showers have been an issue with the facility for a long time. During review of facility form on 7/20/21 at 2:30 p.m. titled Point of Care Audit Report revealed the following lack of documentation of bathing from 5/31/21-7/20/21: a. June 6-June 12 - revealed one shower given. b. June 13-June 19 - revealed one shower given. c. June 20-26- reveled no showers given. d. June 27- July 3-revealed one shower given. e. July 11-July 20 - revealed no shower given. During review on 7/22/21 at 10:00 a.m. of facility form titled Bath, Shower/Tub revised on 2/2018 revealed if the resident refused the shower for any reason this required documentation. During interview on 7/21/21 at 11:21 a.m. the Director of Nursing stated she was aware there was an issue with residents not receiving their baths. The Director of Nursing stated when she started her role in June 2021 there was not a shower list for scheduled baths for the residents. Interview on 7/22/21 at 8:41 a.m. with the Facility Administrator revealed that she expected resident's to be showered at least twice a week and more often if the resident requested.	F 677		

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F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on facility record review, resident and staff interview, and review of facility fall protocol the facility failed to ensure residents call lights and needs were answered/met in a timely manner for 3 of 19 residents, (Resident #15, #32, and #41). The facility failed to answer a call light timely to prevent Resident #15 from assisting herself in her wheelchair and the wheelchair getting stuck	F 725	Tag # F725 Sufficient Nursing Staff **1. Immediate action(s) taken for the resident(s) found to have been affected include:** Resident #15, #32, and #41 call light logs were reviewed on 8-15-2021, A walk through was completed by the Maintenance Director on 08-04-2021 to ensure proper function of call lights. **2. Identification of other residents having the potential to be affected was accomplished by:** A review of call logs was completed on 8-15-2021, any resident noted to have a call light over 15 minutes was reviewed further and addressed. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Education was provided to staff on 7-29-2021 by Marsha James, DON regarding call light response times. The DON or designee will bring the call light logs to stand up daily for review, concerns identified will be addressed and follow up documentation. Call light satisfaction will be discussed during resident council which is scheduled on 8-26-2021. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Administrator or Designee will audit call light response times 5 x's weekly x 2 weeks, then 3 x's weekly x 2 weeks, then weekly x 4 weeks. The Administrator or Designee will bring these audits to the QAPI Committee for review. Any additional audits, education or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/04/2021.	

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F 725	Continued From page 16 resulting in the resident falling out of the wheelchair and fracturing her left distal (far end of) femur. The facility reported a census of 55. Findings include: 1. The Minimum Data Set (MDS) dated 12/24/20 for Resident #15 reported a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. The resident was able to make herself understood and understood others. The MDS coded she required total assistance with 2 staff for transfers, supervision of 1 staff for locomotion on the unit and supervision with set up help for eating. The MDS included diagnoses of heart failure, diabetes mellitus, anxiety disorder, depression and muscle weakness. Resident #15's Care Plan revised 4/6/18 identified her at risk for limitations in ability to perform Activities of Daily Living (ADL's) and directed staff to allow time to complete tasks and to assist with reposition throughout shift. The Care Plan also identified resident at risk for falls and directed staff to anticipate and meet her needs, follow facility fall protocol and place the call light within reach and encourage the resident to use if tor assistance as needed. The facilities document titled Fall- Clinical Protocol revised 3/18 included the following; In addition, the nurse shall assess and document/report the following. a. Vital signs. b. Recent injury, especially fracture or head injury. c. Musculoskeletal function, observing for changes in normal range of motion, weight bearing, etc.	F 725		

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F 725	Continued From page 17 d. Change in cognition of level of consciousness. e. Neurological status. f. Pain. g. Frequency and number of falls since last physician visit. h. Precipitating factors, details on how fall occurred. i. All current medication especially those associate with dizziness or lethargy and j. All active diagnoses. A facility document dated 1/9/21 tiled Un-witnessed for Resident #15 included a Nursing Description, called to Resident #15's room by Certified Nursing Aide (CNA). Upon arrival resident was lying on floor next to bed by window on her back with head laying against bed and feet laying toward bed by door. Resident complained of left knee pain. Resident verbalized tried to get food back close to her so she could eat after moving food to get to purse. Resident verbalized tried to move chair toward table and just fell out. Doctor notified at 1:46 PM. A Progress Note dated 1/9/21 at 1:46 PM documented by Assistant Director of Nursing (ADON) include the following; Called to Resident #15's room by CNA. Upon arrival resident lying on floor next to bed by window. Residents head lying against bed. Resident's feet lying toward bed by door. Lying on back. Wheelchair next to resident. Resident #15 had complaints of left knee pain 5 out of 10 and right knee noted with small sheared area 1 by 1 centimeter (cm). Resident verbalized tried to get food back close to her so she could eat after moving food to get to purse. Resident verbalized tried to move chair towards table and just fell out of wheelchair. Call placed to Dr. to notify of low blood pressure, fall	F 725		

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F 725	Continued From page 18 and increased confusion. The Dr. verbalized wanted her monitored in facility and to call back if blood pressure doesn't self-correct or if the residents respiratory or cardiac status declines. No other complaints. Responsible party aware. Resident denies hitting head, but neurological status initiated for unwitnessed fall. Untitled document provided for call data on 1/9/21 for Resident #15's room included the following; 1/9/21 at 12:31 PM response 7:31 minutes. 1/9/21 at 12:56 PM response 5:03 minutes. 1/9/21 at 1:13 PM response 22:54 minutes. The Computed Radiography (CR) (a digital radiographic that records radiographic images on photostimulable phosphor plates instead of film image receptors) Report dated 1/9/21 at 6:31 PM reason for exam, injury. Clinical indication: left knee twisting injury. Impression: Lipohemarthosis and apparent cortical offset of the tibial plateau, concerning for intra-articular fracture. Further characterization with cross-sectional imagine may be indicated, given limitation of examination due to the degree of osteopenia and varus angulation of knee. The Computed Tomography (CT) (a radiographic technique that produces an image of detailed cross section of tissue) Report dated 1/9/21 at 7:11 PM included clinical indication suspected fracture on radiograph. Impression included comminuted (fracture with more than two pieces may have significant associated soft tissue trauma, direct crushing injury or force to tissues and bone), intra-articular fracture of distal femur. Resident #15's Census listed discharge on 1/9/21 and readmitted on 1/26/21.	F 725		

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F 725	Continued From page 19 During interview on 7/22/21 at 8:59 AM Resident #15 stated staff brought in her food and she could not reach it so she put on her call light and no one came so she tried to move and thinks her call light and or oxygen tubing got caught up in the wheel of her wheelchair. Resident could not move and fell and broke her knee. Resident #15 explained she yelled out and then someone came. During interview on 7/22/21 at 12:00 PM the ADON acknowledged Resident #15 was sitting in wheelchair and leaned forward to reach her tray table and could not reach it. The aide stated to her the table was in front of her when they left the room she had pushed it away to get something and then could not reach it and fell. The ADON stated she did not remember if the call light was on or not. During interview on 7/22/21 at 4:02 PM the Regional Nurse Consultant acknowledged they do not have a call light policy but do have a fall protocol and provided document titled Fall-Clinical Protocol revised 3/18. During interview on 7/22/21 at 4:04 PM the Administrator she explained she would expect regular call lights to be answered within 15 minutes and if a bathroom call light she would expect them to be answered in 5 min. 2. The Minimum Data Set (MDS) assessment dated 6/24/21 for Resident #32 identified a Brief Interview for Mental Status (BIMS) score of 14 out of 15. A score of 14 indicated no cognitive impairment. The MDS revealed the resident required one person assistance from staff for	F 725		

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personal hygiene, transfer, and toilet use. The MDS documented diagnoses that included arthritis, generalized muscle weakness and difficulty in walking.

The Care Plan initiated 6/10/19 encouraged the resident to use bell to call for assistance.

In an interview on 7/19/21 at 1:20 p.m. Resident #32 stated call light is not answered promptly. Resident stated she turned on her call light at 6:10 a.m. and it was answered by staff at 6:50 a.m. Resident #32 stated she watched the clock in her room.

In an interview on 7/21/21 at 10:00 a.m. Resident #32 stated that her call light took over 45 minutes to be answered on 7/20/21 in the morning.

Record review on 7/21/21 at 12:30 p.m. a facility provided form titled Vision Link Call Data revealed on 7/19/21 at 6:04 a.m. for room North 6 (Res #32) call light response was 85 minutes and 15 seconds. Document revealed on 7/20/21 at 6:05 a.m. call response time was 50 minutes and 14 seconds.

In an interview on 7/21/21 at 1:21 p.m. the Facility Administrator stated she expected call lights to be answered within 10 minutes.

3. The Minimum Data Set (MDS) assessment dated 6/30/21 for Resident #41 diagnoses included hypertension, fracture and need for personal care. The assessment documented a Brief Interview for Mental Status (BIMS) score of 12 of 15 which indicated moderate cognitive impairment. The MDS indicated Resident #14 needed extensive assistance for bathing,

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F 725	Continued From page 21 personal hygiene and transferring. The Care Plan initiated 3/02/20 encouraged the resident to use bell to call for assistance. During the group interview on 7/20/21 at 2:10 p.m. Resident #41 stated in the morning his call light takes 20-30 minutes to be answered. Resident #41 stated that he pushed his call light on at 6:30 a.m. this morning and received help from the staff at 7:05 a.m.. Resident #41 stated he had a clock on the wall and he watched the time. Record review on 7/22/at 11:30 a.m. of a facility provided form titled Vision Link Call Data revealed on 7/20/21 at 6:34 a.m. for room North 10 (Res #41) call light response was 36 minutes and 32 seconds. During an interview on 7/22/21 at 11:52 a.m. the Facility Administrator revealed the facility does not have a policy on call light response time.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761	Tag # F761 Label/Store Drugs and Biologicals **1. Immediate action(s) taken for the resident(s) found to have been affected include:** All residents have the potential to be affected. **2. Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential to be affected/	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 22 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to ensure expired medications were discarded and stored medications dated when opened. The facility reported a census of 55 residents. Findings include: 1. Observation on 7/21/21 at 11:20 AM with Staff A, Licensed Practical Nurse (LPN) present, revealed the medication room on the North end contained the following: a. Two unopened bottles of acetaminophen 160mg (milligrams)/5ml (milliliters) liquid expired on 5/2021. b. Two Med Pass 2.0 containers opened but not dated. c. Two unopened peach yogurts expired on 7/12/2021. d. A resident's Mt Dew bottle opened but not dated. 2. Observation on 7/21/2021 at 11:30 AM with Staff A, LPN present, revealed the North end	F 761	**3.Actions taken/systems put into place to reduce the risk of future occurrence include:** All expired and undated items were removed and destroyed immediately. An audit of all medication carts and Medication Storage rooms was completed on 8-9-2021, any expired of undated items were removed. Licensed staff were educated by Marsha James, DON, on medication storage and labeling processes on 8-20-2021 **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The DON or Designee will audit med carts and med storage rooms weekly x 8 weeks. The DON or Designee will bring these audits to the QAPI Committee for review. Any additional audits, education or systemic changes will be addressed by the QAPI committee. Corrective action completion date: 8/20/2021.	

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	165202	A. BUILDING _____ B. WING _____	07/28/2021

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F 761	Continued From page 23 Medication Cart contained the following: a. One stock bottle vitamin B-1 capsules expired 5/2021. b. One stock bottle Geri-Dryl (diphenhydramine) allergy relief expired 2/2021. c. One stock bottle of Mucinex opened but not dated. d. One stock bottle of antacid opened but not dated. e. One stock bottle of MOM (Milk of Magnesia) opened but not dated. f. One stock bottle of lactulose opened but not dated. 3. Observation on 7/21/2021 at 11:58 AM with Staff B, LPN present, revealed the South end Medication Cart contained the following: a. Two stock bottles of guaifenesin expectorant opened but not dated. b. One stock bottle of acetaminophen opened but not dated. c. One stock bottle of aspirin 81 mg opened but not dated. Per the Storage of Medications policy revised on 4/2019, discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During an interview on 7/21/2021 at 2:28 PM, the Director of Nursing (DON), stated there was no process in place for checking medication expiration dates and staff were to date items when opened.	F 761		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services.	F 800		

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F 800	Continued From page 24 The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interviews the facility failed to provide the full serving of pureed meat approved on the menu for week 3 by the dietician for 7 out of 7 residents with pureed meat, (Resident # 5, #7, #19, #20, #21, #24, and #40). The facility reported a census of 55. Finding included: During observation on 7/21/21 at 11:13 AM Staff C Cook added 7, 4 once servings of chicken into the robot coupe and added chicken broth to puree the meat. He measured the total volume after the puree process of 5 cups. He followed the chart to find the scoop size of 1, #8 scoop and 1, #16 scoop for each serving. Placed into a pan covered and placed back into the oven until services. During the observation of meal service Staff C place a #8 scoop into the pureed meat and served all 7 residents, (Resident # 5, #7, #19, #20, #21, #24, and #40) only the #8 scoop and failed to included the #16 portion of meat. After service Staff C measured out 3 #8 scoops of pureed meat left over after service. The Facility policy Therapeutic Diets revised 10/17 included the following; Policy Statement, Therapeutic diets are prescribed by the attending physicians to support	F 800	Tag # F800 Provided Diet Meets Needs of Each Resident **1. Immediate action(s) taken for the resident(s) found to have been affected include:** Resident #5, #7, #19, #20, #21, #24 and #40 the dietitian was notified on regarding portion sized received during meal. Immediately training was provided to Staff C regarding portion/scoop sizes to use. **2. Identification of other residents having the potential to be affected was accomplished by:** A review of resident's diets was completed on 8-18-2021, any resident with a mechanically altered diet, was reviewed to ensure appropriate scoop size was available for use. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** **Staff were educated by the CDM on 8-10-2021 regarding mechanically altered diets and scoop sizes to use. A poster was provided to assist with visual reminder of scoop size recommended for mechanically altered diets.** **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** CDM or designee will audit meal service to ensure appropriate scoop size is used to serve mechanically altered diets 5 x's weekly x 2 weeks, 3x's weekly x2 weeks, then weekly x 4 weeks The CDM or designee will be bringing these audits to QAPI for review. Corrective action completion date: 8/20/2021.	

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F 800	Continued From page 25 the resident's treatment and plan of care and in accordance with his or her goals and preferences. Policy interpretation and implementation: a. A therapeutic diet is considered a diet ordered by physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet for example; Diabetic/calorie controlled diet, Low sodium diet, Cardiac diet and Altered consistency diet. b. If a mechanically altered diet is ordered the provider will specify the texture modification. The Facility Policy Puree Policy reviewed 5/3/21included the following; They follow the recommendations form the Simplified Diet Manual Refer to the heading "Method of Determining the Portion Sizes of Consistency Altered Foods" Charts and tables are available in the food preparation areas for staff to refer to during the puree process. a. Measured out the desired number of servings into container for pureeing . Puree the food. Add any necessary thickener or liquid to obtain desired consistency. b. Measure the volume of the food after it has been pureed. c. Divide the total volume of the pureed food by the original number of portions. This is the new serving size. The Facility Diet Roster included the following; Resident #5 pureed meat. Resident #7 pureed meat. Resident #40 pureed meat. Resident #19 pureed diet. Resident #20 pureed diet. Resident #21 pureed diet.	F 800		

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F 800	Continued From page 26 Resident #24 pureed diet. During an interview on 7/21/21 at 1:49 PM the Dietary Manager explained she would expect staff to label the top of the pan after measuring out the volume and finding out the scoop size so they know what size to use. That is how she trained him.	F 800		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced	F 803	Tag # F803 Menus Meet Resident Nds/Prep in Adv/Followed **1. Immediate action(s) taken for the resident(s) found to have been affected include:** All residents have the potential to be affected. **2. Identification of other residents having the potential to be affected was accomplished by:** All residents have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Education was completed with staff by the CDM on 8-10-2021 regarding meal service to include food temperatures, and food safety. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The CDM of designee will complete meal observations of temperature of food, 5x's weekly x 2 weeks, 3 x's weekly x's 2 weeks, then weekly x 4 weeks. The CDM or designee will be bringing these audits to QAPI for review. Corrective action completion date: 8/20/2021.	

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F 803	Continued From page 27 by: Based on observations, policy review and staff interviews the facility failed to hold food temperatures at an acceptable level to prevent the growth of pathogenic microorganisms that cause foodborne illness. The beginning of meal service the food temperature for the broccoli with cheese sauce and mashed potatoes were under 135 degrees. The facility reported a census of 55. Findings included; Observation at the beginning of the meal service on 7/21/21 at 12:21 PM temperatures included the following; broccoli with cheese sauce 125 degrees and mashed potatoes 130 degrees. The policy titled Food Preparation and Service revised 4/19 included the following; Food Preparation, Cooking and Holding time/temperatures. a. The danger zone for food temperatures is between 41 degrees and 135 degrees Fahrenheit (F). This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. b. The longer food remains in the danger zone the great the risk for growth of harmful pathogens. During an interview on 7/21/21 at 1:49 PM the Dietary Manager explained they had problems with food temperatures and got a new warmer for keeping food warm coming up from the kitchen. She further explained they sent the wrong one.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 28 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview the facility failed to label and store food items appropriately in order to reduce the risk of contamination and food-borne illness. The facility reported a census of 55. Findings included; The initial tour of the kitchen with the Dietary Manager on 7/19/21 at 10:04 AM revealed the following: a. 5 bowls of pureed bread in refrigerator not covered, dated or labeled. b. 1 bag of chopped cabbage 3/4 full in refrigerator opened and not dated. c. 2 quart container of tomato soup not dated or labeled when made.	F 812	Tag # F812 Food Procurement, Store/Prepare Serve-Sanitary **1. Immediate action(s) taken for the resident(s) found to have been affected include:** All residents have the potential to be affected. **2. Identification of other residents having the potential to be affected was accomplished by:** All residents had the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Items located in the kitchen that were undated, were immediately removed and discarded. The refrigerator was cleaned on 8/19/2021 and is on a routine cleaning schedule. The dietitian completed a sanitation audit 8/19/2021. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The CDM or designee will complete a sanitation audit to include cleanliness of kitchen storage and dating of open items 3 x's weekly x 2 weeks, then weekly x 4 weeks. The CDM or designee will be bringing these audits to QAPI for review. Corrective action completion date: 8/20/2021.	

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F 812	Continued From page 29 d. 1 open bag in the freezer containing 18 premade pancakes not dated or sealed. e. Freezer the bottom left side with a large amount of purplish sticky substance. Facility policy Food Receiving and Storage revised 2017 included the following; Food shall be received and stored in a manner that complies with safe food handling practices. a. Food Services, or other designated staff, will maintain clean food storage areas at all times. b. All Foods stored in the refrigerator or freezer with be covered, labeled and dated . During an interview on 7/21/21 at 8:14 AM the Dietary Manager explained she would expect the staff to date and label all food items stored.	F 812		