| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035088 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Camelback Post Acute Care and Rehabilitation | 4635 North 14th Street<br>Phoenix, AZ 85014 |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911<br><br>Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure one resident's (#81) clinical record included the required information for transfer/discharge. The deficient practice could result in residents not having a safe and effective transition of care.<br><br>Findings include:<br><br>Resident #81 was admitted on [DATE] with diagnosis including an unspecified fracture of the right femur, end stage renal disease, osteomyelitis, encounter for orthopedic aftercare following surgical amputation, complete amputation of left foot, dependence on renal dialysis, type II diabetes mellites with diabetic polyneuropathy, chronic systolic heart failure and aneurysm of iliac artery. It was further noted in the electronic health record that the resident left the facility against medical advice on August 20, 2023.<br><br>A review of the MDS (minimum data set) revealed no noted score for the BIMS (brief interview of mental status).<br><br>A review of the electronic medical record, revealed no evidence of documentation that EMS (emergency medical services) arrived at the facility on August 20, 2024.<br><br>A review of the electronic health record revealed that an AMA (against medical advice) form was completed by staff #121, RN (registered nurse) on August 20, 2023 at 4:17 P.M.<br><br>A review of the medical record revealed that staff #121, RN (registered nurse) conducted the discharge. Staff #121 is no longer with the facility. An attempt was made to contact staff #121 telephonically on April 24, 2024 at 9:58 A.M.; however, the associated voicemail was full and the surveyor was unable to leave a message.<br><br>An interview was conducted on April 24, 2024 at 8:40 A.M. with staff #1, CNA (certified nursing assistant). Staff #1 stated that she would notify the nurse if a resident wanted to leave against medical advice. She stated that she would then help collect the resident's belongings in preparation for departure. She stated that discharge documentation is then provided by the nurse.<br><br>(continued on next page) |

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.

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

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on April 24, 2024 at 8:43 A.M. with staff #11, RN (registered nurse). Staff #11 stated that when a resident wants to leave against medical advice, the nurse would discuss the consequences with the resident. Staff #11 stated that if the resident wanted to proceed with leaving, he would notify the resident's emergency contact and inform the doctor. Staff #11 stated that he would have the resident sign the AMA form and if EMS was present, provide documentation to the EMS staff to include the face sheet, medical diagnosis, medication orders and recent laboratory progress notes.<br><br>An interview conducted on April 24, 2024 at 9:05 A.M with staff #21, case manager. The case manager stated that when a resident wants to depart the facility AMA (against medical advice), she would speak with the resident to try to get them to reconsider. If the resident does not wish to reconsider, she stated that she would discuss the issue with the team to see if there is a possibility to change the AMA departure to a possible discharge. She stated that she would notify the resident's nurse if the resident opted to continue with leaving against medical advice. Once the nurse is notified, she stated that the nurse would provide the documentation for discharge. The case manager stated that she would inquire about the need for any DME (durable medical equipment) and inquire if the resident had any concerns. Staff #21 stated that staff would inquire about transport and provide notifications; however, she stated if the resident opted to leave against medical advice and the fire department is called then no one is notified, but documentation would be provided to the fire department.<br><br>An interview was conducted on April 24, 2024 at 10:17 A.M. with EMS staff #120. Staff #120 stated that he reviewed the documentation of the call on August 20, 2023. He stated that it was noted that EMS staff arrived at the facility at 4:04 P.M. and were not provided any verbal or written report regarding the resident's condition. The electronic health record noted that the AMA form was signed by resident #81 and staff #121 at 4:17 P.M. after EMS arrival at 4:04 P.M.<br><br>An interview was conducted on April 24, 2024 at 10:32 A.M. with staff#29, DON (director of nursing).<br><br>Staff # 29 stated that if a resident had chosen to leave the facility against medical advice, she would first ensure that the resident was not confused and if they were she would make sure that a responsible family member was with them, if possible. She stated that the facility would offer home health, medications and transfer to another facility, as applicable. She stated that her expectation would be for staff to document everything regarding the AMA discharge; however, the medical record for resident #81 revealed no documentation of EMS arrival and or report to EMS on August 20, 2024 for AMA discharge. Staff #29 reviewed the medical record and stated that there was no documentation that EMS had arrived at the facility on August 20, 2024. She stated that her expectation is that information would be shared with either EMS and or the resident, but the medical record revealed no evidence that discharge or transfer documentation had been shared. She stated that the risk to resident would include a lack of continuation of care.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of facility policy in the Continuum of Care section, entitled Discharge against Medical Advice with a revised date on May 6, 2021revealed that appropriate instructions are to be given to the resident and the instructions given are to be documented in the record; however, the record revealed no evidence of documentation of instructions given to either the EMS or the resident. The policy further revealed that the facility is to facilitate the coordination of a safe discharge; however, per EMS interview, no written or verbal report had been provided by the facility on August 20, 2024. Finally, the policy stated that all occurrences and steps throughout the situation are to be documented in nursing notes; however, there is no evidence in the nursing notes that EMS arrived at the facility to remove the resident on August 20, 2023. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on clinical record review, staff and resident interviews and policy review, the facility failed to ensure one resident's (#44) representative was able to participate in the care planning process. The deficient practice could result in residents and representatives not participating in and understanding their plan of care.<br><br>Findings include:<br><br>Resident #44 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included urinary tract infection, atrial fibrillation, aphasia, and cognitive communication deficit.<br><br>Review of the cognition care plan initiated on November 20, 2023 indicated that the resident is at risk for impaired cognitive function/dementia or impaired thought process. Interventions include to communicate with family/caregivers regarding resident's capabilities and needs, and social services to provide psychosocial support as needed.<br><br>The resident's admission record indicated that the resident has two emergency contacts. The first emergency contact (primary) is his son and the secondary emergency contact is his wife.<br><br>Review of the resident's clinical record revealed that the most recent documented contact regarding a care conference was back in December 12, 2023. According to the progress note, the contact was regarding setting up a care conference was not directed to the identified emergency contacts but rather to the resident's other son. There was no documentation on whether or not a care conference was actually completed. Further review of the resident's record did not reveal any recent documentation pertaining to care plan conferences.<br><br>The quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 2 indicating that the resident has severe cognitive impairment.<br><br>During an interview with resident #44's son conducted telephonically on April 21, 2024 at 12:26 p.m., he stated that he has not been informed/invited to care plan meeting recently even if he is the primary emergency contact. He stated he has had some concerns regarding his father's care and would like to be part of care conferences so he is aware of what is going on.<br><br>An initial interview was conducted with the Director of Nursing (DON/staff #29) on April 24, 2024 at 9:38 a.m. The DON stated that care conferences for long term care residents are conducted quarterly by social services and in 1-2 days by the case manager for skilled residents.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Social Services Director (staff #7) was conducted on April 24, 2024 at 9:42 a.m., she stated that care conferences for long term care residents are usually accomplished quarterly. When asked when resident #44 last had his care conference, she stated that it was December 2023. Staff #7 indicated that the next one will be scheduled April 2024. She noted that they normally give the family a week's notice. When asked if the care conference for resident #44 was schedule, she noted that it has not yet been scheduled but will be scheduled. She stated that they normally notify the wife but not the son. Staff #7 said that normally they invite the family member that is indicated as emergency contact #1 or 2, the wife, and adult child. She said that she does not maintain a tracker to monitor who is due for their care plan conference. Staff #7 stated that she goes by when the MDS is due. However, when asked why resident #44's care conference was not done when his MDS was done in February 20, 2024, she stated that she would like to go by the MDS due date but that is not what they are currently doing. Staff #7 stated that her current process is reviewing the list of her residents weekly and see who is due. She said that the impact of not conducting the care conference and inviting family to the care conferences is that there might be something that is not discussed regarding a resident's care and services that needs to be addressed.<br><br>A follow-up interview was conducted with the DON (staff #29) on April 24, 2024 at 1:08 p.m., staff #29 stated that her expectation regarding care conferences is that it will be done quarterly and that both the resident and the family are invited. The DON indicated that is a resident has a low BIMS score, she expects for the family or responsible party to be invited to the conference. Staff #29 stated that care conferences should be scheduled based on the family's availability. If are resident was due this month, then they should have already been notified and the conference already scheduled based on family's availability.<br><br>Review of the facility policy titled Comprehensive Person-Centered Planning reviewed February 2024 indicated that the facility will provide the resident and the resident representative advance notice of care planning conferences to encourage resident and/or resident representative participation. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581<br><br>Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure that a potentially dangerous item was not left in a public area on one resident's (#1) mobile tray where other residents could access it. The deficient practice could result in residents injuring themselves.<br><br>Findings include:<br><br>On April 21, 2024 at 8:27 a.m., a mobile tray was observed in the hallway by room [ROOM NUMBER]. There was a blue razor with a clear plastic cover over the blade on the tray and the tray was left unattended.<br><br>An interview was conducted on April 21, 2024 at 8:37 a.m. with a certified nursing assistant (CNA/staff #88), who stated that they put the mobile tray outside of the resident's room because there is no room for his wheelchair. She stated that the razor is supposed to be thrown away once it has been used and there is a risk of residents cutting themselves on the razor. After the interview, staff #88 began walking away and the surveyor had to intervene and ask her to remove the razor from the tray.<br><br>During an interview conducted on April 21, 2024 at 10:36 a.m. with resident #1, he stated that the staff put his mobile tray in the hallway, so there is room for the Hoyer lift when he is being assisted with transfers.<br><br>An interview was conducted on April 23, 2024 at 2:16 p.m. with a registered nurse (RN/staff #11), who stated that a razor should be removed if not being used and put in a sharp container right away, if it are disposable. He stated that if a razor is left out in common area, there is a risk of residents being injured.<br><br>An interview was conducted on April 4, 2024 at 3:12 p.m. with the Director of Nursing (DON/staff #29), who stated that staff should put razors in the sharps container when done because there is a risk of another resident getting the razor and cutting himself/herself if left in a common area.<br><br>The facility policy, Elopement/Unsafe Wandering dated December 2023 states that It is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment and interventions. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581<br><br>Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure that one resident (#1) was assessed for the risk of entrapment when using full size bedrails on both sides of the bed and to assess and document the ongoing need for bed rails. The deficient practice could result in residents being physically injured.<br><br>Findings include:<br><br>Resident #1 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, muscle spasm of the back, disorder of the autonomic nervous system and depression.<br><br>Review of the Assistive Device Consent form dated September 18, 2019 did not reveal a consent for the use of two full size bed rails.<br><br>The care plan dated September 24, 2019 included that the resident has quadriplegia related to a spinal injury status post a motor vehicle accident in 1991. Interventions included two full side rails up when in bed for unsafe jerky movements related to muscle spasms.<br><br>The resident's care plan dated September 24, 2019 states the resident is at risk for falls related to quadriplegia, psychoactive drug use, spasms, impaired range of motion. Interventions included full size bed rails for muscle spasms related to quadriplegia.<br><br>Review of the Fall Risk Evaluation dated May 10, 2021 revealed that the resident had not fallen in the last three months, did not have a decrease in muscular coordination, or jerking movements.<br><br>The order summary revealed an order dated January 12, 2022 for two full side rails up when in bed for unsafe jerky movements related to muscle spasms every shift.<br><br>Review of the Assistive Device Consent form dated February 14, 2022 revealed a consent for the use of two full size bed rails for bed mobility/repositioning.<br><br>Review of the Restraint/Enabling Device/Safety Device Evaluation dated April 21, 2022 The assessment states that the bed rails potentially protect the resident, increases sense of safety/security per the resident's request. The risks include death by strangulation, suffocation, contractures, and accidental injuries.<br><br>Review of the Assistive Device Consent form dated February 24, 2023 did not reveal a consent for the use of two full size bed rails.<br><br>Review of the Restraint/Enabling Device/Safety Device Evaluation dated February 24, 2023 did not include an assessment for full size bed rails.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Restraint/Enabling Device/Safety Device Evaluation dated June 2, 2023 did not include an assessment for full size bed rails.<br><br>Review of the Fall Risk Evaluation dated February 6, 2024 revealed that the resident had not fallen in the last three months, did not have a decrease in muscular coordination, or jerking movements.<br><br>Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated February 2024, March 2024, April 2024 revealed two full side rails up when in bed for unsafe jerky movements related to muscle spasms every shift, but did not reveal that muscle spasms were being tracked.<br><br>Review of the Restraint/Enabling Device/Safety Device Evaluation dated March 5, 2024 revealed an assessment for grab bars.<br><br>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 15 indicating the resident was cognitively intact. It also included that the resident is dependent on staff assistance with rolling from left and right and a bed rail is not used.<br><br>Review of the Restraint/Enabling Device/Safety Device Evaluation dated April 23, 2024. The assessment states that the bed rails potentially protect the resident, increases sense of safety/security per the resident's request. The risks include death by strangulation, suffocation, contractures, and accidental injuries.<br><br>Review of the EMAR progress notes from February 2024 through April 2024 did not reveal that the resident had any muscle spasm.<br><br>On April 23, 2024 at 1:22 p.m. the resident was observed lying in bed and long bed rails on both sides of the bed were in the up position.<br><br>On April 24, 2024 at 10:14 a.m. the resident's bed was observed up against the left wall and he was lying in bed with full size bed rails up on both sides of the bed, and there were no pads on the rails.<br><br>An interview was conducted on April 23, 2024 at 1:24 p.m. with a certified nursing assistant (CNA/staff #51), who stated that a resident needs an assessment for bed rails and they are used because a resident may roll from one side of the bed to the other and can fall on the floor.<br><br>An interview was conducted on April 23, 2024 at 2:16 p.m. with a registered nurse (RN/staff #11), who stated that the resident wanted the bed rails to balance his communication board, to use the remote and call-light. He stated that the resident balances these things up against the bed rail and uses the pointer in his mouth to draw on the board, access the remote, and call-light. He stated that the resident needs an assessment for the bed rails to determine if the resident still needs them.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on April 23, 2024 at 3:12 p.m. with the Director of Nursing (DON/staff #29), who stated that an assessment must be completed for a resident to use bedrails. She reviewed the Restraint/Enabling Device/Safety Device Evaluation dated March 5, 2024 and stated that resident was assessed for grab bars and he is not able to use his hands to use the grab bars. She stated that the resident needs the full size bed rails because he has muscle spasms. She reviewed the resident's MAR and TAR, but was not able to find where the resident's spasms were being tracked and stated that she would need to search for the tracking.<br><br>The facility policy, Restraints, Physical dated October 2023 states that the use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>40581<br><br>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that a registered nurse (RN) provided eight hours of coverage in a 24 hour period.<br><br>Findings include:<br><br>Review of the daily staff posting dated December 24, 2023 revealed that the census was 82. There were four licensed practical nurses (LPNs) from 6:00 a.m. to 6:00 p.m. and seven certified nursing assistants (CNAs) from 6:00 am. to 2:00 p.m. for the day shift. There were six CNAs from 2:00 p.m. to 10:00 p.m. There were four LPNs from 6:00 p.m. to 6:00 a.m. and four CNAs from 10:00 p.m. to 6:00 a.m.<br><br>During an interview conducted on April 23, 2024 at 9:16 a.m. with the Staffing Coordinator (staff #75), the daily staff posting dated December 24, 2023 was reviewed and Staff #75. She stated that the census was 82 and that there were four (LPNs) from 6:00 a.m to 6:00 p.m. and four LPNs from 6:00 p.m. to 6:00 a.m. She stated that the facility is required to for 8 hours daily and she could not find one for December 24, 2023. She stated that she called the Director of Nursing (DON) to tell her that registry did not have a RN available. She stated that the DON can't stand for a RN when the census 82.<br><br>During an interview conducted on April 23, 2024 at 3:01 p.m. with the (DON/staff #29), she stated that a registered nurse must be scheduled to work 8 consecutive hours daily, and it her responsibility to ensure that a RN is scheduled.<br><br>The facility policy, Staffing dated January 2024 states that there will be 8 hours of RN coverage on a daily basis. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>40581<br><br>Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure that the daily staff posting reflected the correct information.<br><br>Findings include:<br><br>An observation of the daily staff posting was conducted on April 21, 2024 at 7:15 a.m. The daily staff posting was posted on the wall behind the receptionist's desk. The date on the posting was April 19, 2024 with a census of 76. The census for April 21, 2024 was 75.<br><br>An interview was conducted on April 21, 2024 at 7:15 a.m. with a licensed practical nurse (LPN/staff #6, who stated that she thought the charge nurse updates the daily staff posting when she comes in to work at 10:00 a.m.<br><br>An interview was conducted on April 21, 2023 at 8:57 a.m. with the receptionist (staff #109), who stated that the Staffing Coordinator (staff #75) usually posts the daily staff posting and is usually here by 8:00 a.m. During the interview, it was observed that there was not a daily staff posting on the wall and staff #109 stated that she usually looks at the posting to ensure that the date is correct and didn't know why there wasn't a posting when she arrived to work this morning.<br><br>An interview was conducted on April 23, 2024 at 9:16 a.m. with the Staffing Coordinator (staff #75), who stated that she is responsible for updating the daily staff posting. She stated that she works Monday through Friday and has not designated another staff to update the posting on the weekend, and when she arrived this morning, there was not a daily staff posting on the wall.<br><br>An interview was conducted on April 23, 2024 at 2:56 p.m. with the (DON/staff #29), who stated that<br><br>the daily staff posting is completed by the Staffing Coordinator (staff #75), and it is her expectation that staff #75 will complete the postings for the weekend and put them behind the Friday posting, so the weekend staff can rotate them. She stated that the purpose of daily staff posting is to show residents and visitors what the staffing is for the day and should include the census, date, floor staff, and the number of hours worked for each position.<br><br>The facility policy, Staffing Numbers, Posting dated May 2022 states that it is the policy of this facility to post staffing numbers. Procedures include to comply with the Benefits Improvement and Protection Act of 2000, the facility must include hours worked by registered nurses, licensed practical/vocational nurses, and nursing assistants for each shift. Post prominently in a public area in readable font on a surface of at least 8.5 x 11 inches. The policy doesn't include the correct date and census. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035088 | A. Building<br>B. Wing | 04/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Camelback Post Acute Care and Rehabilitation | 4635 North 14th Street<br>Phoenix, AZ 85014 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on observations, staff interview, and policy review, the facility failed to ensure food items were labeled and dated, food items were not expired, temperature logs were maintained, equipment was sanitized, and food was served under sanitary conditions. The deficient practice could increase the risk of foodborne illness.<br><br>Findings include:<br><br>Regarding food labeling and dating:<br><br>During the initial kitchen observation conducted on [DATE] at 7:17 a.m., two items wrapped in foil was found in the walk-in freezer which was unmarked/not labeled and not dated.<br><br>Additionally, cereal dispenser for what appears to be Rice Krispies, Raisin Bran, Corn Flakes, and Cheerios did not have an expiration date. A bin containing oatmeal was marked ,d+[DATE] but it is unknown if that is the filled date or the expiration date. A bin containing lentil was marked ,d+[DATE] and did not specify if it was the fill date or expiration date. A container marked bread crumbs was labeled ,d+[DATE] but the same container was also marked Panko with a date of ,d+[DATE]. It is unknown if the item is regular bread crumb or Panko and if the date is the filled date or expiration date.<br><br>A look at the nutrition fridge located by room [ROOM NUMBER] conducted on [DATE] at 8:00 a.m., revealed what appears to be two peanut butter and jelly sandwiches that was undated/unmarked.<br><br>During a follow-up kitchen observation conducted on [DATE] at 2:58 p.m., it was observed that 2 shelves of jello cups were undated in the walk-in fridge.<br><br>Additionally, 5 racks of bread loaves was observed undated. Information regarding the product is normally on the shipping box but was not transcribed/marked on each individual package.<br><br>The facility's undated kitchen policy titled Food Storage and Date Marking indicated that all containers must be legible and accurately labeled if product is not easily identifiable. An open date is recommended. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated if stored for over 24 hours. TCS (Time and Temperature Control For Safety) foods should be covered, labeled and dated if stored and not for immediate use. All foods will be checked to assure that foods will be consumed by their use by dates, or frozen or discarded at the end of the day. Use by dates for TCS foods are 7 days or less of prep date.<br><br>Regarding expired items:<br><br>During the initial kitchen observation conducted on [DATE] at 7:17 a.m., a container of low-fat cottage cheese marked ,d+[DATE] with a best if use by date of [DATE] was found in the walk-in fridge.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility's undated kitchen policy titled Dry Storage Areas indicated that foods with expiration dates are used prior to the date on the package.<br><br>Regarding temperature logs:<br><br>An initial kitchen observation conducted on [DATE] at 7:17 a.m. Review of the temperature log for the both the walk-in fridge and walk-in freezer revealed that the last time the temperature was checked/documented was [DATE] which was three days prior.<br><br>The facility's undated kitchen policy titled Food Storage and Date Marking indicated that temperature for the refrigerated food should be checked routinely to check for proper functioning of the unit. The policy also noted that freezer temperatures should be checked daily for proper functioning.<br><br>Regarding sanitary kitchen and conditions:<br><br>During the initial kitchen observation conducted on [DATE] at 7:17 a.m., it was observed that the ceiling fan facing the dishwasher station was dusty. The fan had dust covering a majority of the cover. The fan was located above 2 wire racks where dishware, cups, drinkware, and baking sheets were stored. Four small plates located on the wire rack under the ceiling fan was observed to be dirty/dusty.<br><br>Additionally, the hood above the oven was observed to be dusty and grimy. The dust and grime had a brownish/black appearance.<br><br>Review of the kitchen's cleaning checklist for the aides revealed that it was last completed on Thursday, [DATE] for the a.m. shift and Tuesday, [DATE] for the p.m. shift. The cleaning checklist for cooks for the week of [DATE] was last completed on Thursday, [DATE] for the a.m. shift and on Monday, [DATE] for the p. m. shift. Additionally, the dishwasher cleaning checklist was last completed on Thursday, [DATE].<br><br>In a follow-up kitchen observation conducted on [DATE] at 10:29 a.m., the ceiling fan facing the dishwasher station was still observed dusty.<br><br>Additionally, the pipe by the counter where pureed meals are prepared was observed to to have a clump of dusty strings hanging down from the pipe/ceiling.<br><br>During the tray line observation conducted on [DATE] at 11:37 a.m., it was observed that the vent over the tray line counter was dusty.<br><br>Additionally, during the tray line observation conducted on [DATE] at 11:37 a.m., the heating element containing the spinach/greens was observed to have what appears to be a piece of an alcohol prep packet. The staff did not seem to notice that the food contained a foreign object.<br><br>On [DATE] at 11:44 a.m., the Dietary Supervisor (staff #44) was asked what the foreign object/item was on the spinach/greens. Staff #44 removed the item and scooped around the area where the item was. He indicated that it was probably from when they temperature checked the dish earlier. The batch was still used and served to the residents.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During the tray line observation, it was noticed that the vent above the tray line counter was blowing cold air directly down on the food in the tray line.<br><br>During another follow-up kitchen observation conducted on [DATE] at 2:58 p.m., it was observed that the ceiling fan facing the dishwasher station was still dusty. The vent above the tray line was also noticeably dusty. Furthermore, the pipe located above where pureed meals are prepared still had the dusty clump of string hanging from it.<br><br>An interview with the Dietary Supervisor (staff #44) conducted on [DATE] at 2:58 p.m., he stated that when the ceiling fan is dusty then dust probably flies to where the dishes are. Potentially, dust can also go over to the tray line. The kitchen is supposed to be clean and sanitary. Staff #44 stated that when a foreign item is found in a dish/food, then the entire batch of that meal item should be thrown away. However, he indicated that he got nervous and that is why it was not done. The purpose of throwing out the entire batch of that meal item is to ensure the safety of residents and ensure they are taken care of.<br><br>Review of the facility's undated kitchen policy titled General Sanitation of Kitchen, indicated that food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.<br><br>The facility's undated kitchen policy titled Food Storage and Date Marking indicated that Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581<br><br>Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure that dirty dishes were not left in a common areas where residents have access, and that common areas were cleaned and disinfected. The deficient practice could result in residents becoming ill or infected.<br><br>Findings include:<br><br>On April 21, 2024 at 8:27 a.m. brown liquid in a gray cup with a straw was observed on a mobile tray in the 200 hall just outside a resident's room and it was unattended. Also, a tray was observed in the Northeast dining room with toast, leftover cereal in a bowl that resembled heart shaped Cheerios, one bowl of leftover oatmeal and milk, leftover scrambled eggs on the plate, and orange liquid in a Styrofoam cup with a straw. The tray was unattended and there were three residents sitting in the dining area watching TV.<br><br>On April 21, 2024 at 8:49 a.m. feces, approximately 1.5 inches, was observed in the middle of the hallway in front of room [ROOM NUMBER]. Staff were observed walking by it. One nurse stopped the surveyor from stepping in it and said that someone will come to clean it up and then walked away. One certified nursing assistant (CNA/staff #4) was observed wearing a glove, and picking the feces up. Then, staff #4 walked away and did not disinfect the floor. Shortly after, a male staff was observed walking and wheeling a cart over the area.<br><br>On April 23, 2024 at 2:06 p.m., a three tiered black tray was observed in the hallway by the kitchen doors at approximately 1:15 p.m. until approximately 2:00 p.m. There were dirty dishes with leftover rice, carrots, bread, and chicken, a clear glass with 1/4 of a red drink, and opened coffee creamer wrappers. The food was not covered.<br><br>During an interview conducted on April 21, 2024 at 8:37 a.m. with a certified nursing assistant (CNA/staff #88), she observed the brown liquid in the gray cup sitting on a mobile tray in the hallway just outside the resident's room. She stated that it was leftover coffee. She stated that leftover food and drinks are not supposed to be left in common areas because there is a risk of cross contamination and safety.<br><br>An interview was conducted on April 23, 2024 at 2:16 p.m. with a registered nurse (RN/staff #11), who stated that dirty dishes should be removed immediately from hallway and dining room to prevent other residents from having access because there is a risk of infection. He stated that if there is feces on the floor, staff should use bleach, something to disinfect the floor, and if the area is not disinfected, there is a risk of spreading infection as people walk through the area and then to other areas.<br><br>If a resident finds feces on the floor, the CNA blood or anything like a secretion. Should use bleach, something to disinfect the floor, and if not disinfected could spread infection if people walking through and then to other areas.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An interview was conducted on April 23, 2024 at 3:12 p.m. with the Director of Nursing (DON/staff #29), who stated that it is her expectation that staff remove dirty dishes from the rooms and place them in a closed cart because the dishes are dirty/contaminated, and residents could become ill. She stated that if there is feces in the hallway, staff should use gloves and pick it up, and the floor should be bleached/sanitized. She stated that if staff are walking through the area or pushing equipment through it, it would track the feces elsewhere and creates the risk of contamination/infection.<br><br>The facility policy, Infection Prevention and Control Program dated December 2023 states that process surveillance is the review of practices by staff directly related to resident care. Some considerations for this process may include cleaning and disinfection production and procedures for environmental surfaces and equipment. The facility will use effective methods for the safe storage, transport and disposal of garbage, refuse and infectious waste, consistent with all applicable local, state, and federal requirements for such disposal. |