STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Tallahassee	3101 Ginger Dr Tallahassee, FL 32308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45951 Based on observations, review of the electronic medical record (EMR), interviews with staff and residents, and review of the facility policies and procedures, the facility failed to provide a dignified existence for 5 of 6 residents sampled for dignity. (Residents 104, 65, 116, 41, and 120) The findings include: Resident #104 During a tour of the facility conducted on 06/17/24 at 2:53 PM, Resident #104 was observed lying in bed in a hospital gown. When asked why Resident #104 was in a hospital gown, Resident #104 stated she had no clean clothes. She stated she had talked to housekeeping staff and to nursing staff and each told her the responsibility of resident's personal laundry fell on the other. Resident #104 gave the surveyor permission to open her closet, and inside the surveyor observed bags and piles of clothing. (Photographic evidence obtained with resident's verbal permission) Resident #104 verified these clothes were all dirty and in need of laundering. When asked if she was wearing a hospital gown due to her lack of clean clothing, she stated Yes, I only have one clean dress and I was going to wear it tomorrow. A review of records revealed the most recent Quarterly Minimum Data Set completed on 04/27/24 revealed Resident #104 had a Brief Interview of Mental Status Score of 7, which indicated she had cognitive impairment. An interview was conducted with the Housekeeping Administrator on 06/19/24 at 2:45 PM. She stated the staff responsible for transporting resident's personal laundry was the nursing staff, specifically the Certified Nursing Assistants (CNAs). She said the CNAs were responsible for bagging the resident's personal laundry and placing a paper slip in the laundry bag containing the resident's name and room number. She said the CNAs then either took the dirty laundry bag to the soiled utility room or directly to the laundry room for processing. She said the residents or their families were encouraged to label their own clothing so that it did not become lost at the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105433	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff M, CNA, on 06/20/24 at 1:12 PM. Staff M confirmed she was assigned to care for Resident #104 often. Staff M said she had spoken to Resident #104 numerous times regarding her personal laundry not being done. She said it was not her responsibility as a CNA to take a resident's laundry to the laundry room but rather it was the responsibility of the laundry staff to collect the soiled personal laundry from each resident's room. She said when the clothes were returned by the laundry staff, they sometimes hung the clothes in the resident's closets but other times the laundry staff placed a bag of clean clothes on the chair in the room and then the CNAs hung the clean clothes in the closets as they had time. She said resident's families often labeled the clothing but that if a resident's clothing was not labeled, they would place a paper inside the laundry bag so the laundry staff knew who the laundry belonged to. An interview was conducted with Resident #104 on 06/20/24 at 2:26 PM. She stated her clean clothes were hung in her closet on 06/19/24. During this interview, Resident #104 was lying in bed, fully dressed. She stated she was happy that she had her clean clothes hung in her closet. She further stated she was happy that she was able to wear her clothes instead of a hospital gown. 42756 Resident #65 and #116 On 06/18/24 at approximately 10:25 AM, an interview was conducted with Resident #65. He was wearing a patient gown. He indicated that he has no clothes to wear. He said he came to the facility without any clothes. He has had to wear a gown every day. Resident #65 was asked if he likes wearing a gown. He said no, and indicated that he would prefer to wear clothes instead of a gown. On 06/18/24 at approximately 5:07 PM, an observation was made of resident #65 wearing a gown. On 06/19/24 at approximately 9:19 AM, Resident #65 was once again observed wearing a patient gown. An interview on 06/18/24 with Resident #116 at approximately 10:45 AM revealed he also had no clean pants to wear. He explained that he often has to re-wear his pants because he only has a few pants and he does not get them back from laundry. He was wearing a pair of black pants. There was a small bag of soiled clothes in his room. Resident #116 said he had previously filed a grievance regarding this. On 6/19/24 at approximately 3:16 PM, observations were made in the laundry room. There were 5 extra-large bags on the floor. A sign above the bags said Please do not touch. Washing and sorting. Another shelf had bedspreads and pillows stored up to the ceiling. There was a rolling rack for hangers with clothes hung up and labeled by the room. The bottom shelf of the rack had unfolded clothes both bagged and out of bags piled up. There was another rack that had a clear bag of what appeared to be clothes lying on the floor. (photographic evidence obtained). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aspire at Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 Ginger Dr Tallahassee, FL 32308	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Laundry Services Supervisor was interviewed and indicated that the clothes in the bags lying on the floor had been washed and were waiting to be sorted. When the surveyor pointed out the bags were stored on the floor, she explained that clothes in the bags would be re-washed, dried, and sorted. The Laundry Services Supervisor indicated that they have been short staffed in laundry and have not had the staff to deal with sorting resident clothing. She explained that there are currently 3 staff working in the laundry. Two weeks ago the facility had only 2 people processing personal laundry. She indicated more of the clothes have just recently been reprocessed. She pointed at the folded clothing on the shelves. She explained that 6 people have been hired to work in laundry services in recent weeks. She explained that she has only worked for the facility for three months and they have been actively working to improve laundry services. The Laundry Services Supervisor indicated that resident's clothing has been a daily topic in the morning meetings. She indicated that the facility administration is aware and they are working together to correct the problem. The District Manager of Housekeeping Services was interviewed and explained that the expectation is that it takes no more than 48 hours to process items that come into the laundry room. The Director Of Nursing (DON) was asked to provide initial inventories of personal effects for Residents #65 and #116. She was also asked to provide a copy of the grievance completed by Resident #116. On 6/19/24 at approximately 4:40 PM, a review of the facility grievance log was conducted. The log indicated that a grievance was filed on 5/15/23 by Resident #116 regarding missing clothes. The resolution section on the log stated that the clothes had been found and returned and the complainant was notified of the resolution on 5/20/24. On 6/19/24 at approximately 5:28 PM, an interview was conducted with the Facility Administrator (FA). He indicated that the facility did have issues with laundry supplies about 6-7 months ago but it has been corrected since. The FA mentioned that they do clothing drives and supply clothes to the residents who need them. He explained that is the family's responsibility to label the clothing for residents. When items get lost, facility staff goes through everything trying to find the lost item. On 06/20/24 at approximately 8:30 AM, Resident #65 was once again observed in bed asleep wearing a patient gown. On 06/20/24 at approximately 11:30 AM, Resident #65 was awake and indicated that he has not received any clothes yet. The surveyor asked for permission to look in his closet. In the closet, there was a long sleeve sweater hanging and a pair of pants, but nothing else (photographic evidence obtained). Immediately afterwards, the other resident, #116 was observed to be wearing the same black pants on that he wore on 6/18/24. On 6/20/24, a review of the Inventory of Personal Effects form dated 4/27/23 for Resident #65 was conducted. The form indicated that he came to the facility with no personal belongings when he entered the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Inventory of Personal Effects form dated 4/27/23 for Resident #116 was conducted. Based on the inventory, the resident came into the facility with 2 pairs of shorts, 2 pairs of sweat pants, 1 pair of suit pants, and 1 pair of pants. On 06/20/24 at approximately 3:10 PM, an interview was conducted with the Director of Nursing (DON). She was notified that Resident #65 wore a gown every day of the survey. He came into the facility with no clothes and expressed wishes to have clothes to wear. The DON said the facility would go buy him clothes immediately. She was also notified about Resident #116 who said he has no pants to wear. On 06/20/24 at approximately 3:19 PM, an interview was conducted with the Regional Social Services Director (SSD) regarding the initial inventory for Resident #65. The SSD stated that he came into the facility on [DATE] with no clothes and has been wearing patient gowns everyday. The Resident reported that he wished to wear clothes instead of a gown. She indicated that clothes should be provided and this would be corrected. She said a grievance has been filed on behalf of resident #65 and #116. She indicated that resident #116 has 4 pairs of pants in his closet now. 35609 Resident #41 On 06/18/24 at 9:30 AM, Staff A, a Certified Nursing Assistant (CNA A), was observed moving Resident #41 in a mechanical lift taking the resident into the bathroom. The resident was observed to have their pants down around the ankles with their unclothed mid section to their ankles visible from the hallway. The door was open and the resident's wheelchair was in the doorway. On 6/18/24 at approximately 9:31 AM, an interview was conducted with CNA A, who was asked why she was providing toileting care with the door wide open. She stated she did not close the door because there wasn't enough room to close the door and the resident was rushing her. On 6/19/24 at 11:50 AM, an interview was conducted with Resident #41, who stated they wished the staff would close to door and did not like they were exposed naked from the waist down. On 6/19/24 at approximately 1:42 PM, an interview was conducted with the Director of Nursing (DON) who stated she expected staff to close the doors and close privacy curtains when care is provided. The DON stated the door should have been closed. On 6/19/24 a review of the facility policy, Privacy effective 11/30/14, states, Procedure: 1. The Nursing Home staff will recognize that residents and their families need a place of privacy. 2. Resident's privacy will always be respected. 3. Facility will provide time and space for privacy. 50082 Resident #120 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/2024 at approximately 10:50 AM, an observation of Resident #120's room revealed that the dresser and hanging clothing armoire are turned around with the doors and drawers facing the wall, prohibiting the resident access to belongings. (photographic evidence obtained) On 6/17/2024 at approximately 11:00 AM, an interview with staff V, a certified nursing assistant (CNA V), was performed, She stated that the dressers for Resident #120 were turned around to face the wall to limit the resident's access to them, as the resident is often getting into the clothing and changing several times a day. She indicates Resident #120's clothing is kept in the activities room on a hanging cart that the resident cannot access. On 6/18/2024 at approximately 07:43 AM, Resident #120 was observed wearing a sweat suit with her name written in large print on the front right chest in marker. On 06/19/2024 at approximately 03:30 PM, Resident #120 was observed wearing a shirt with her name labeled on the right front chest. On 06/20/2024 at approximately 08:00 AM, during an interview with Staff U, another CNA, she indicates that the facility does the laundry for Resident #120. Staff will label the clothing before it is sent to laundry. She indicates the process for labeling the clothing is with a marker and should be written on the back neckline near the tag. A review of the resident's record for Resident #120 reveals a care plan dated 9/22/2023 with goals related to self-care performance deficit. Interventions include assisting the resident to choose simple comfortable clothing that enhances the resident's ability to dress themself and allow sufficient time for dressing and undressing. The resident requires assistance by staff to dress. A review of the policy named Processing Resident Personal Clothing policy 6-33 dated 02/01/2003 indicates that all residents clothing for residents in Long Term Care facility must be labeled in a manner that is both practical and respects the dignity of the resident. A small permanent tag or label is placed in the most inconspicuous place on every article of clothing.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42756 Based on observations and staff interviews the facility failed to provide a safe, clean, and homelike environment in the laundry room, main hallway, and the 100 and 200 residential areas. The findings include: On 6/19/24 at 2:51 PM, a tour of the facility laundry services area was conducted with the Facility Administrator (FA), District Manager of Housekeeping Services, the Facility Laundry Services Supervisor, and the Plant Operations Director. Upon opening the door to the soiled laundry processing area, concerns were identified. On the right side of the room was a shelf overflowing and stacked with linens to the ceiling. A blue disposal can was directly in front of the shelf with linens stacked up on top. There were also linens on the floor below the shelf. The left side of the room had another shelf stacked with pillows to ceiling. There were several items on the soiled concrete floor including towels, sheets, and gowns in bags that were partially opened. There was a bed spread thrown on the floor. In between the washing machines, there were two large garbage disposal bins without lids. (photographic evidence obtained) On 6/19/24 at approximately 3:06 PM, interviews were conducted in the area. The Laundry Services Supervisor explained that the contents of both shelves were waiting to be discarded. She was asked why there were so many items stacked up. The Plant Operations Director indicated that sometimes floor staff use items stored on the shelves to do the floors. The District Manager of Housekeeping Services was asked about the garbage cans between the laundry room. He indicated that the cans should not be in the area and would be moved. On 6/19/24 at 3:16 PM, observations were made in the personal clothing room. There were 5 extra-large bags on the floor. A sign above the bags said Please do not touch. Washing and sorting. Another shelf had bed spreads and pillows stored up to the ceiling. There was a rolling rack for hangers with clothes hung up and labeled by the room. The bottom shelf of the rack had unfolded clothes both bagged and out of bags piled up. There was another rack that had a clear bag of what appeared to be clothes lying on the floor (photographic evidence obtained). The Laundry Services Supervisor indicated that the clothes in the bags lying on the floor had been washed and were waiting to be sorted. When the surveyor pointed out the bags were stored on the floor. She explained that clothes in the bags would be re-washed, dried, and sorted. The Laundry Services Supervisor indicated that they have been short staffed in laundry and have not had the staff to deal with sorting resident clothing. She explained that there are currently 3 staff working in the laundry. Two weeks ago, the facility had only 2 people processing personal laundry. She indicated more of the clothes have just recently been reprocessed. She pointed at the folded clothing on the shelves. She explained that 6 people have been hired to work in laundry services in recent weeks. She explained that she has only worked for the facility for three months and they have been actively working to improve laundry services. The District Manager of Housekeeping Services explained that the expectation is that it takes 48 hours is the goal to process items that come into the laundry room that is the goal. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/19/24 at approximately 4:41 PM, the District Manager of Housekeeping Services reported that the trash cans had been removed from next to the washing machines. Both shelves that were overstocked with linen and pillows in the soiled laundry room had been discarded. The shelves have been removed as well. He indicated that the facility will order sorting bins to be used in the future. A review of the facility Laundry Process dated 1/1/2000 was conducted. The policy indicated that soiled linen should be transported in containers or barrels marked soiled linen only. According to the process, soiled linen containers were to be lined with an impervious liner and contain a lid. The process indicated that containers should be checked frequently to prevent overflow of soiled laundry. As soon as linens are removed from the dryer they should be folded. The folding process must keep pace with the washers and dryer and there should never be a back up on clean linen waiting to be folded. A review of the Processing Resident Personal Clothing process dated 2/1/2003 was also conducted. The process indicated that clothing should not accumulate in the laundry. Unmarked clothing should be brought to the units for identification on a daily basis. Racks of hung and folded clothing should be delivered daily either by nursing personnel or laundry staff. 45951 During a tour of the facility conducted on 06/17/24 at 5:40 PM, six unidentified large brown/green semi-liquid piles were observed throughout a main hallway of the facility leading from the dining room door to the laundry room door. One pile appeared to have been tracked through with a wheel (photographic evidence obtained). While attempting to identify the substance, six facility employees were observed walking down the hallway past the piles, past the facility's administrator's office, and out the front door without alerting any staff of the issue. The surveyor also observed one resident walk through the area with a cane. The facility's administrator, Director of Nursing, and regional nurse were made aware of the piles of unidentified matter throughout the hallway posing a slipping hazard to anyone walking through the hallway. The Director of Nursing stated she would call housekeeping to clean up the piles. An environmental tour of the facility was conducted on 06/19/24 with two surveyors, the facility's Administrator, Plant Operations Manager, Housekeeping Administrator, and District Manager of Housekeeping Services. The following environmental concerns were observed (photographic evidence obtained): In room [ROOM NUMBER], the windowsill had fallen down and was lying on the floor; there was heavy wear on the wall near the room entrance with exposed metal. In room [ROOM NUMBER], there were 3 stained ceiling tiles above the bathroom and entrance of the room. In room [ROOM NUMBER], there were dark brown stains present on the privacy curtain and floor. In room [ROOM NUMBER], an armchair present near the room doorway was noted to be heavily soiled. There was heavy wear on the wall in the laundry room, causing exposed metal. In the shower room on the 100 hallway, the floor had unidentified brown matter present under a shower chair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the shower room on the 200 hallway, the floor was chipping/peeling paint.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35609 Based on observation, interview, policy review, and record review, the facility failed to ensure accuracy of Preadmission Screening and Resident Review (PASARR) for 3 of 3 residents sampled (Residents #18, #62, and #126). The findings include: Resident #18 On 6/19/24, a review of the PASARR for Resident #18, dated 3/3/17, was conducted. There was no evidence of a Level II being completed in the electronic record although the form did denote the resident had a primary diagnosis of dementia and suspected mental illness. On 06/20/24 at 9:37 AM, an interview was conducted with the Regional Social Services Director, who reviewed the electronic chart and verbally acknowledged the document and that there is no Level II review in the electronic record. She stated she it most likely got lost during the transition of the medical record migration and it was possible it just didn't get scanned into the electronic record. On 6/20/24 at 10:32 AM, an interview was conducted with the Regional Clinical Director, who stated they and could not locate a Level II PASARR for this resident. Resident #62 On 6/18/24 a record review was conducted for Resident #62. The PASARR, dated 1/18/23, indicated no suspected mental illness. A review of the resident's medical record had documented diagnoses of recurrent depressive disorders added on 1/25/23, schizophreniform disorder added on 6/15/23, anxiety disorder added on 4/20/23, generalized anxiety disorder added on 1/25/23, and brief psychotic disorder added on 4/7/23. There was no updated PASARR in the electronic medical record. On 6/20/24 at 2:30 PM, an interview was conducted with the Regional Director of Social Services, who reviewed Resident #62's list of diagnosis and the PASARR form. She verbally agreed the diagnoses were absent from the PASARR and stated a new Level I PASARR should have been completed as the one from the hospital was not accurate. 42756 Resident #126 On 6/19/24, a record review was conducted for Resident #126. The resident was admitted to the facility on [DATE]. The admission form indicated that Resident #126 had been diagnosed with bipolar disorder, recurrent depressive episodes, and schizoaffective disorder that were present upon admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission history and physical at the hospital indicated that Resident #126 had a past medical history of bipolar disorder and schizoaffective disorder. According to the history and physical, Resident #126 was prescribed the following psychotropic medications: Seroquel 100mg by mouth daily at bed time, Olanzapine 2.5 by mouth mg twice a day and Duloxetine 30 mg by mouth once a day. A review of the care plan indicated that Resident #126 uses psychotropic medications to treat bipolar disorder and schizoaffective disorder. On 6/20/24, the Director of Nursing (DON) was asked to provide the most recent PASARR form on file for Resident #126. A review of the PASARR form provided by the DON was conducted. The form was dated 3/14/24. Section I of the PASARR form did not indicate that the resident had been previously been diagnosed with bipolar disorder or schizoaffective disorder. Section IV of the PASARR indicated that Resident #126 had no diagnosis or suspicion of serious mental illness and that a level II PASARR evaluation was not required. There was no other documentation of an updated PASARR or evaluation in the record. On 06/20/24 03:19 PM, an interview was conducted with the Regional Social Services Director for the facility. When she was shown the PASARR on file at the facility, she indicated that the PASARR form would be corrected. A review of facility policy regarding PASARR forms dated 11/8/21 was conducted. The policy stated that it is the responsibility of the center to assess and assure the preadmission screenings are conducted and results obtained prior to admissions and are placed in the appropriate sections of the resident's record. If it is learned after admission that a PASARR Level II is indicated, it is the responsibility of Social Services to coordinate or inform the appropriate agency to conduct the screening. Results of screening evaluations will be incorporated into the individual resident's plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50082 Based on observations, staff interviews, and review of the electronic medical record (EMR), the facility failed to develop a comprehensive care plan for anxiety for 1 of 2 residents sampled. (Resident #123) The findings include: On 6/17/2024 at approximately 2:30 PM, Resident #123 was heard calling out help me, I can't breathe. Nursing staff responded and placed oxygen on the resident. The resident continued to call out and appeared anxious. On 06/20/2024 at approximately 09:18 AM, during an interview with Staff S, a licensed practical nurse (LPN), she stated, The resident can become agitated at times but is usually easy to redirect. She does not have any PRN (as needed) medications for anxiety, just scheduled Trazadone. A review of the EMR revealed the resident was admitted on [DATE] and had a diagnosis of anxiety disorder. A review of physician orders found an order initiated on 06/13/2024 for Trazodone (a medication used to treat depression) 25 mg twice a day. An order was placed on 5/17/2024 for psychology and psychiatry as needed. An additional order for a psych consult was ordered on 5/30/2024 to evaluate and treat for medication management related to anxiety disorder. The resident's care plan, initiated on 5/17/2024, does not include a plan or interventions for monitoring the resident's mood, behavior, or anxiety. A psych noted dated 06/06/2024 from the Psychiatric Mental Health Nurse Practitioner indicated the resident's mood is agitated related to wound care, her appearance/behaviors are calm. It further indicates the resident has a past psychiatric history of depression and anxiety.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Aspire at Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 Ginger Dr Tallahassee, FL 32308	

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 48176 Based on observation and interview, the facility failed to consistently post nurse staffing information. The findings include: On 6/19/24 at approximately 9:11 AM, staffing was not posted on the 100 and 200 halls. On 6/20/24 at approximately 10:09 AM, staffing was not posted on the 100 and 200 halls. On 6/20/24 at approximately 10:30 AM, Staff O, Licensed Practical Nurse (LPN), for the 100 hall was interviewed. When asked if she was the one responsible for updating the board, she stated she was. When asked why it had not been updated in a couple of days, she stated she thought it was getting done. On 6/20/24 at approximately 10:34 AM, Staff N, the LPN for the 200 hall, was interviewed. When asked about the staffing board, she stated she had not updated it that day. She tries to do it first thing when she comes in but does not always have time. She also stated it is the nurse's responsibility to update it every shift, it just does not always happen right at the beginning of the shift.

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	105433	A. Building B. Wing	06/20/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50783 Based upon record review and staff interview, the facility failed to ensure the accuracy of narcotic counts and that the stored narcotics were consistent with physician orders for 1 of 37 residents reviewed, Resident #143. The findings include: A review of Resident #143's narcotic count sheet revealed tablets were present in the medication cart for Hydrocodone/APAP Tablet 5-325 1 tablet by mouth every 6 hours as needed for non-acute pain. The count on the narcotic book sheet was 66. The number of tablets present in the medication cards was a total of 65. Staff P stated she had given Resident #143 this medication at 12:00 PM and had not signed it out of the narcotic book. She confirmed that she had signed it out of the computerized Medication Administration Record (MAR). When asked to review the physician order page, the computer order was for Hydrocodone/APAP Tablet 7.5-325 1 tablet every 6 hours related to other low back pain. Further review of the computerized MAR revealed the order was written on 05/30/24. In an interview conducted with Staff P during this observation, she confirmed she was unaware that the order had changed and Resident #143 had received the wrong order. Staff P stated she would call the physician regarding the medication error and that she would discuss the error with the facility's Director of Nursing.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50783 Based on observation, record review, and staff interview, the facility failed to properly store medications maintain medication carts, including disposal of expired medications and properly labeling medications in 3 of 3 medication carts reviewed. The findings included: A medication cart observation was conducted on 06/20/24 at 3:15 PM with Staff N, a Licensed Practical Nurse (LPN) for the Split Haven medication cart. The following areas of concern were identified (photographic evidence obtained): -4 white unidentified tablets were observed in the top left drawer of the medication cart. LPN N disposed of these medications into the sharp's container located on the side of the medication cart when this was brought to her attention. -4 multicolored tablets were observed in the 3rd drawer on the right side of the medication cart. LPN N disposed of these medications into the sharp's container located on the side of the medication cart when this was brought to her attention. -A Levemir insulin pen lacked an open date. It is unknown if this medication was used, however, per the pharmacy label, if it was unopened, it should have been refrigerated. -Dorzolamide eye drops lacked a pharmacy label/name and there was no received date from the pharmacy noted. An interview was conducted with LPN N at the end of this observation regarding the disposal of the loose medications found in the cart. LPN N confirmed that she disposed of the medication tablets into the sharp's container on the side of the medication cart. When asked if the facility provided a pill buster solution for the nurses to dispose pills into, she stated there was a bottle of pill buster solution in the medication storage room. She stated she was aware that she should have taken the tablets to the pill buster bottle for disposal. A medication cart observation was conducted on 06/20/24 at 3:46 PM with LPN O for the 100-hall medication cart. The following areas of concern were identified: -6 white unidentified tablets were observed in the top left drawer of the medication cart. LPN O disposed of these medications into the pill buster located in the medication room when brought to her attention. -An unidentified multi dose vial of Lidocaine was observed with no label from the pharmacy or date opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1 white unidentified tablet was observed in a drawer of the medication cart. LPN O disposed of these medications into the pill buster when brought to her attention. -Two Symbicort inhalers lacked a pharmacy label/name and had no received date from the pharmacy. -25 multicolored tablets were observed in the medication cart. LPN O disposed of these medications into the pill buster when brought to her attention. -A ProAir RespiClick inhaler lacked a pharmacy label/name and had no received date from the pharmacy. -A Multi dose vial of Novolog insulin was observed lying in the medication cart with no open date or received date from the pharmacy. -An Insulin Glargine pen lacking an open date, it is unknown if this medication was used, however, per the pharmacy label, if it was unopened, it should have been refrigerated. -A Novolin pen was observed lacking an open date, it is unknown if this medication was used, however, per the pharmacy label if it was unopened, it should have been refrigerated. A medication cart observation was conducted on 06/20/24 at 4:37 PM with LPN P for the 300-hall medication cart. The following areas of concern were identified: -1 unidentified tablet was observed at the bottom of the medication cart. LPN P verbalized she planned to flush this tablet down the toilet to dispose of it. When asked what the facility policy was for disposal of medications, she verbalized the policy was to use the pill buster solution. -A Glucose Gel was observed with an expiration date of 01/2023. An interview was conducted with the facility Director of Nursing (DON) on 06/20/24 at 5:30 PM in which the above areas of concern were discussed. The DON stated the pharmacist had come to the facility to conduct medication cart audits, during which he had audited each medication cart for expired or unlabeled medications. The DON provided to the surveyor a copy of audits conducted by the pharmacist, dated 06/12/24. Review of the facility policy titled Medication Storage, undated revealed the following: Medications will be stored in a manner that maintains the integrity of product and ensures the safety of the residents; Medications will be stored in an orderly, organized manner in a clean area; Medications will be stored in the original, labeled containers received from the pharmacy; Expired medications will be removed from the medication storage area and disposed of in accordance with facility policy.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 50082 Based on observations, resident intervew, staff interview, review of meal tray tickets and electronic medical record (EMR) review, the facility failed to serve each resident a palatable diet and failed to address special dietary needs and physician orders for 3 of 7 residents sampled for food related concerns, Resident #22, #248 and #135). The findings include: Resident #22 On 06/17/24 at approximately 01:50 PM, Resident #22 was observed with a lunch tray in front of her. She indicated she just returned to the facility from dialysis. Resident #22 reported she does not get a bagged lunch on the days she is out of the facility for dialysis. On 06/18/24 at approximately 08:28 AM, Resident #22 stated she frequently does not get what is on her meal ticket, it often is missing cereal, jelly and margarine. Resident #22 stated her roommate's family provides snacks and individual microwave meals that she supplements with. An observation at this time of Resident #22's meal ticket indicates, NO MILK, but there were two cartons of milk observed on the tray, she received toast without the jelly and margarine. On 06/19/24 at approximately 08:10 AM, Resident #22 was observed sitting in her wheelchair. She had finished her breakfast which included 2 boiled eggs, raisin bran cereal with milk and oatmeal. The meal ticket still indicates NO MILK as well as 3 slices of bacon, which the resident did not receive. Resident #22 indicated she has never received the bag lunch on her dialysis days, which are Monday, Wednesday, and Friday. She reported she has lived at the facility for approximately 3 years. On 06/20/24 at approximately 08:24 AM, Resident #22 was observed sitting in her wheelchair in her room. The meal ticket once again indicated NO MILK, yet she had a bowl of raisin bran cereal with milk on her tray. A review of the EMR revealed Resident #22 had a diagnosis of dependence on renal dialysis and end stage renal disease (ESRD). A review of the physician's orders include orders dated 3/22/24 indicate to send a bagged lunch with the resident for dialysis. Resident 22's diet order states no dairy. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/20/24 at approximately 2:22 PM, the kitchen manager stated that the residents in the building that are on dialysis receive bag lunches on the days they go out. The van drivers will go to the kitchen and request the lunch bag before leaving the facility. Staff H indicates Resident #22 is served a large breakfast prior to leaving the facility on dialysis days. Staff H indicates that Resident #22 is always back from dialysis in time for lunch at the facility and always has a lunch tray delivered to her room, she also gets a lunch bag all three days. Staff H confirms that she is aware Resident #22's meal ticket indicates NO MILK. When asked about the observations of milk on the resident's tray for four days in a row, the kitchen manager stated that, if the resident is receiving milk on her tray, it is her kitchen staff not reading the ticket. Staff H stated that kitchen staff place condiments such as margarine and jelly on the carts in bulk when they are sent to the floor, it is the responsibility of the floor nursing staff to give the residents the condiments when they pass trays. 42756 Resident #248 On 06/17/24 at approximately 3:59 PM, an interview was conducted with Resident #248. She reported that the food is often cold and does not taste good. She often does not eat what is served at the facility because she had found the food to be overall unacceptable. She reported that she has told staff about this numerous times in the weeks she has lived at the facility. On 6/19/24 at approximately 8:00 AM, Resident #248 said again she did not eat her breakfast tray today or yesterday. She restated that she often does not eat the food. She stated that when she does eat the facility's food, her stomach gets upset and she gets diarrhea. She explained that the breakfast yesterday morning was not good and the she did not like the alternative offered by the facility which was cereal or warm milk. Her tray was still at the bedside. The ticket said 2 buttermilk pancakes, 1 diet syrup, 1 margarine, 2 slices of bacon, 6 oz of hot cereal, 8 oz of milk, 4 oz of orange juice, and 6 oz of coffee or hot tea. She reported that the milk was warm and she did not open it. She did not receive syrup or margarine or coffee/tea with her breakfast. The milk on the trays felt warm to touch . The Resident said she could not eat dry pancakes and dry cereal and warm milk. On 6/19/24 at approximately 11:32 AM, while Resident #248 was being escorted out of her room by Certified Nursing Assistant C, she could be heard in the hallway telling the nursing assistant not to bring her lunch tray. She explained that she did not want to eat her lunch because the food is terrible. On 06/20/24 at approximately 8:32 AM, Resident #248 said she had her own food for breakfast and did not want her breakfast tray today. Resident #135 (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/19/24 at approximately 8:00 AM, an interview was conducted with Resident #135. She complained that the food was cold most of the time. She said sometimes the food appears to be undercooked. She said she was served Italian sausage that appeared to be raw the other day. The resident verbalized concerns for people who are disoriented or confused and unable to notice concerns with the food quality. She complained that trays are often missing condiments. The servings are often small. She explained the other day she got one small chicken wing for the meat portion of her meal. Resident #135 said the milk is often warm. She said she often gets diarrhea and wonders if the food might be contributing to the diarrhea. She showed the surveyor her tray. She had dry pancakes with no margarine or syrup to apply to the pancakes. The milk on the tray felt warm to touch. The ticket said 2 buttermilk pancakes,1 diet syrup, 1 margarine, 2 slices of bacon, 6 oz of hot cereal, 8 oz of milk, 4 oz of orange juice, and 6 oz of coffee or hot tea. (photograph evidence obtained). On 6/19/24 at approximately 12:45 PM an interview was conducted with CNA C. The surveyor mentioned Resident #248 and #135 had complaints about their breakfast that morning and the trays had no margarine or syrup on the trays. She explained that the margarine and syrup is on the side. CNA C replied that residents have to ask for the condiments and staff will get them whenever they ask.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45951 Based on observations, staff interviews, and policy review, the facility failed to store, prepare, and serve food in accordance with professional standards of food service safety. There were issues found with the dish cleaning process, cold food storage, non-food items and personal drinks stored on food preparation stations and a lack of hair containment during food preparation. The findings include: A tour of the kitchen was conducted on 06/17/24 beginning at 12:01 PM. Upon entering the dishwasher room, the following was observed: -Two juice cups and one soup bowl were on the floor of the dishwasher room along with garbage, debris, and a large amount of water. -The ceiling above the dishwasher was rusted through and appeared to be falling apart. -A large amount of limescale buildup was observed on the front of the dishwasher. -The hose for the hand sprayer nozzle and a pipe located under the sink area were both observed with water flowing freely from them. -There was food matter falling under the sink and disposal area due to improper water flow through the drain and garbage disposal area. Staff were observed standing in puddles of water on the floor. -The outside of the garbage disposal had a large amount of rust present along with water and food particles. -Two baking sheets were present on the dish drying rack with pieces of parchment paper lying on them-the parchment paper had water and debris present on its surface. -The dish drying rack contained a large amount of rust on the surface. -A large pile of food particles was observed on the clean side of the dishwasher. -There was a rack of clean dishes which also contained a large buildup of food particles. An interview was conducted with the facility's Kitchen Manager during the observation. When asked if it was normal to have this amount of buildup of food particles on the clean side of the dishwasher, the Kitchen Manager stated, they should wipe that up. Continued tour found: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A silverware cart contained an employee identification badge, eyeglasses, a resident room television remote, and numerous rubber bands. -Two food preparation tables were observed, one of which contained two covered personal drinks, a personal cell phone, and a Bluetooth speaker and the other contained two uncovered personal drinks. -Mops were stored inside of a bucket in the storage closet preventing proper drying. -The sugar bucket in the dry storage room had a large buildup of a wet, brown substance on the inside and outside of the container. -The can shelving unit in the dry storage room had a buildup of glue and stains. -There was a broken shelf at the top center of the shelving unit in the dry storage room. -There was a large buildup of grease on the tops of the iced tea maker and ice machine along with a buildup of an unidentified black substance on the wall behind the ice machine. -The back outside entrance door of the kitchen was propped open with various bottles while exiting and re-entering the kitchen. -The handwashing sink lacked a garbage can with a foot pedal-operated lid. Closer observation revealed the closest garbage can was near a food preparation table approximately 15 steps away. This garbage can had a regular, lift-off lid. -A reach-in milk refrigerator contained cartons of milk did not feel cool to the touch. There was no thermometer in the refrigerator. (Photographic evidence obtained) Upon entering the walk-in refrigerator on 06/17/24 at 12:18 PM, it was observed that there was a large amount of water on the floor of the refrigerator and condensation build up on all containers in the refrigerator. It was also observed that the inner handle of the refrigerator door was broken and had come loose from the inside of the door. There was a large buildup of a black substance on the floor. There was a broken thermometer mounted on an inner wall of the refrigerator. The Kitchen Manager was asked if this was the thermometer the staff used to check the refrigerator's temperature daily. The Kitchen Manager stated this was the thermometer the staff used. The Kitchen Manager was shown that the thermometer was broken, missing approximately a half an inch of glass from the middle of the thermometer. She then stated there was a different thermometer that was used but she did not know where it was located within the refrigerator. Further inspection of the refrigerator revealed a thermometer that had fallen off a shelf next to the door. This thermometer stated the temperature in the refrigerator was 60 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Upon entering the walk-in freezer, located at the back of the walk-in refrigerator, the surveyor tripped over a buildup of ice on the floor on the inside of the freezer door, approximately 1.5 inches tall. The Kitchen Manager stated the buildup of ice had been there for some time. It was observed that there was a large build up of ice on the ducting and wiring of the cooling mechanism fan. The temperature in the freezer was 10 degrees F. The Kitchen Manager stated that the staff had been entering and exiting the refrigerator and freezer as they had recently finished lunch service. She stated it was very warm in the kitchen that day and that the refrigerator had trouble keeping its temperature when the temperature was warm. When asked how long this had been a concern, she stated it had been an issue for over a year. She stated she had spoken to the administration about her concern in the past but that nothing had been done. An interview was conducted with the facility's Kitchen Manager on 06/17/24 at 2:02 PM concerning the above areas of concern. She agreed the personal drinks, cell phone, and speaker should not have been present on the food preparation stations. She agreed the eyeglasses, TV remote, ID badge, and rubber bands should not have been present on the silverware cart. She stated she was not aware that the dishwasher was leaving food particles on the dishes but stated that the dishes would be re-washed prior to the next meal service. During a follow-up tour of the kitchen conducted on 06/18/24 at 11:13 AM, Staff R, Dietary Aide, was observed placing food onto plates from the service line. When asked if the temperatures had been taken prior to service, Staff R stated she did not know. She further stated there was a book on the preparation table that would include the temperatures taken by the cook (staff I). She said the cook was on break and unavailable for interview. When asked if she was told by Staff I (Cook) to begin plating the food, she stated she had not been told but that it was time to begin the meal service. During this interview, at 11:16 AM, Staff I, Cook, entered the kitchen. She confirmed she had just returned from her lunch break. She stated she was going to obtain the food temperatures prior to lunch service. Staff I was observed fastening her employee identification badge to her shirt. She then proceeded to don gloves to take food temperatures without first washing her hands. Staff I obtained a digital thermometer and cleaned it with an alcohol wipe prior to taking the food temperatures. Continued observation revealed Staff I obtained the temperatures of each food but between each food, she did not use a wipe to clean the thermometer but rather used the palm of the glove she was wearing. Closer observation revealed the wrist of the glove she was wearing dipped into the foods as she was obtaining the temperatures. It was noted that, while she was obtaining the temperatures of the foods, she was not documenting the temperatures on her log. Later review of the food temperature log conducted on 06/18/24 at 12:04 PM revealed that Staff I had not recorded the temperatures she had obtained. An interview was conducted with the kitchen District Manager on 06/18/24 at 12:05 PM. When showed that the temperature log was lacking the temperatures for the lunch meal, he stated the staff were nervous because we were there. When asked if the lack of documentation of temperatures was appropriate, he stated that it was not appropriate workflow and that there would be corrective action taken. Review of the facility's policy titled Environment, revised date 09/2017 revealed that all food preparation areas will be maintained in a clean and sanitary condition. Review of the facility's policy titled Food: Preparation, revised date 02/2023 revealed that temperature for foods will be recorded at time of service. Lack of Hair Containment: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the initial tour of the kitchen conducted on 06/17/24 at 12:01 PM, the surveyor observed Staff E, Dietary Aide, and Staff G, Dietary Aide, in the kitchen food preparation area without beard nets despite having facial hair. Staff I, Cook, was also observed with her hair not fully contained in a hair net in the food preparation area and dish washing area. Closer observation revealed Staff I had acrylic nails, approximately 1 inch long. Her acrylic nails were adorned with beads and jewels. An interview was conducted with Staff I on 06/18/24 at 10:28 AM. She stated her job duties as a cook at the facility included prepping food, cooking, doing dishes, keeping her preparation area clean, and serving food. While interviewing the Kitchen Manager on 06/17/24 at 1:20 PM, the facility Administrator was observed entering the kitchen and walking through the preparation area to the other side of the kitchen without wearing a hair net. Upon realizing he was being observed, the Administrator quickly turned and exited the kitchen. An interview was conducted with the facility's Kitchen Manager on 06/17/24 at 2:02 PM. The manager was asked about misuse of hair and beard nets by the staff. She stated the staff were aware that they should wear hair and beard nets while in the kitchen and that they were supposed to don their hair nets before entering the kitchen area. An additional observation conducted on 06/17/24 revealed Staff F, Dietary Aide, enter the kitchen and walk through the preparation area to the other side of the kitchen without wearing a hair net. When the Kitchen Manager asked him to don a hair net prior to entering the preparation area, he stated I just got here. Further observation revealed when he did don a hair net, he did not fully contain his hair within the hair net. Additional observations conducted on 06/18/24 revealed Staff E wearing a beard net improperly, in a manner which did not cover his facial hair but rather left the beard net was located under/behind his facial hair. Interviews were conducted with Staff E and Staff G on 06/18/24 at 10:30 AM. They stated their job duties as dietary aides included prepping food, doing dishes, taking out the garbage, working on the food service line, and pushing meal carts to the units. Review of the facility policy titled Authorized Kitchen Personnel, revised date 09/2017 revealed all authorized personnel must wear appropriate head covering while in the kitchen or production area. Review of the facility policy titled Staff Attire, revised date 10/2023 revealed the following: All staff members will have their hair confined in a hair net or cap and facial hair properly restrained Use of nail polish, acrylic and gel nails are not permitted Review of the facility policy titled Food: Preparation, revised date 02/2023 revealed all staff will practice proper hand washing techniques

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 45951 Based on observations, staff interviews, and policy reviews the facility failed to maintain all garbage areas in a safe and sanitary manner. The findings include: Upon initial entrance of the facility on 06/17/24 at 11:35 AM, an observation of the dumpster area located at the side of the building in the main parking lot was made. It was observed that a moderate amount of garbage and medical waste was present on the ground in front of and surrounding the two dumpsters. The first dumpster appeared to be in clean condition. Further observation revealed approximately 12 wooden pallets were being stored behind or next to this dumpster. The second dumpster was observed to have a side access door open. Closer observation revealed a broken plastic cart, a broken and rusted metal cart, and a broken wooden table were being stored behind this dumpster. Later observations of the dumpster area conducted on 06/17/24 at 5:45 PM revealed the same amount of garbage and medical waste present on the ground in front of/surrounding the dumpsters. During this observation, the top plastic cover of the second dumpster was observed to be open. Additional observations conducted on 06/19/24 at 10:00 AM revealed an area alongside the building behind the dumpster area in which was found five garbage cans. Further inspection revealed three of these garbage cans housed bags of linens from inside the facility. In this same area, there were 2 broken plastic carts, a broken plastic shelving unit, and a broken wheelchair. In an area near by (approximately 10 steps away), the surveyor observed a broken plastic cart containing no less than 3 plastic milk crates along with other garbage, one plastic and one wooden pallet, a plastic structure, a pile of planting pots, and three broken toilets. An interview was conducted with the facility's Plant Operations Manager during this tour. He stated he was aware that there were pallets and broken tables and carts behind the dumpsters. He said that the pallets were picked up each week on Fridays. When asked when the pallets were last collected, he did not have an answer. When asked if twelve pallets were typical build up/expected for over a weekend, he did not answer. When asked how long the carts and table had been behind the second dumpster, he did not answer. When asked why there were bags of facility linens being stored in garbage cans behind the facility, he admitted he had seen the cans in front of an exit door and had asked a staff member to move them, but he did not specify to the staff member where to put them and he had not inspected the contents of the cans before they were moved; he said he did not follow up with the staff member to find out where the cans were moved to. When asked how long ago they had been placed behind the dumpster area, he did not answer. When asked how long the other items had been in this same area, he again did not answer. Review of the facility's policy titled Dispose of Garbage and Refuse, dated 08/2017 revealed the following: (continued on next page)

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	105433	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Tallahassee	3101 Ginger Dr Tallahassee, FL 32308

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All garbage and refuse will be collected and disposed of in a safe and efficient manner; The area surrounding the exterior dumpster area is maintained in a manner free from rubbish or other debris; Appropriate lids are provided for all containers. Review of the facility's policy titled Environment, revised date 09/2017 revealed that all trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris.

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NAME OF PROVIDER OR SUPPLIER Aspire at Tallahassee		STREET ADDRESS, CITY, STATE, ZIP CODE 3101 Ginger Dr Tallahassee, FL 32308	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 45951 Based on observations, interviews, and policy reviews the facility failed to maintain food service related equipment in safe operating condition in the kitchen and food pantries. The findings included: Kitchen sink: During the initial tour of the kitchen conducted on 06/17/24 at 12:01 PM, upon entering the dishwasher room, it was observed that a large amount of water was present on the floor of this room. Closer observation revealed there was a sprayer nozzle hanging over a sink area which had a large amount of water coming out of the hose. It was also observed there was water pouring out of a pipe under the sink. Further observation revealed, on the right side of the dishwasher, that there was a large buildup of food particles present along with a rack of clean dishes which also contained a large buildup of food particles. An interview was conducted with the facility's Kitchen Manager at this time. The manager was asked to explain if this was the dirty side, where the dirty dishes entered the dishwasher. The Kitchen Manager stated this was the clean side, where the clean dishes exited the dishwasher. When asked if it was normal to have this amount of buildup of food particles on the clean side of the dishwasher, the Kitchen Manager stated, they should wipe that up. An additional observation of the dishwasher room was conducted on 06/17/24 at 1:20 PM during which Staff E, Dietary Aide, was rinsing dishes, placing them into racks, and putting the racks through the dishwasher while Staff G, Dietary Aide, was receiving the cleaned dishes on the other side of the dishwasher. Upon retrieving a rack of clean dishes, it was observed that there were soup bowls and coffee mugs present in a flat rack; there were no securing or stabilizing areas of the dish rack to hold the dishes properly in place. The surveyor observed the soup bowls were turned bowl-side up and contained water with soap bubbles and food particles. When asked if these dishes were clean, Staff G stated the dishes were clean as they had just come from the dishwasher. When asked if it was typical to have water with soap and food particles present in clean dishes, Staff G held up two soup bowls and stated, Its fine, I just shake the water out of them before I put them on the drying rack and demonstrated shaking the water and food particles onto the floor of the room before then placing the bowls onto the dish drying rack to his right. An interview was conducted with the facility's Kitchen Manager on 06/17/24 at 2:00 PM during which the above concerns were discussed. The Kitchen Manager stated the dishes would be rewashed prior to the next food service. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the facility's Administrator on 06/17/24 at 4:49 PM. He stated he had heard there was a concern regarding the dishwasher that morning. He stated the staff had not assembled the dishwasher properly that morning and that there were supposed to be plastic curtains that hung down from the top of the machine on each side to stop the food particles from coming out. He stated the dishwasher had been properly reassembled and that the food particles would no longer be a concern. He further stated the sprayer nozzle had been fixed, so the floor would no longer have water on it. The Administrator was told that the concern was not only the sprayer nozzle but also the pipe under the sink which was leaking water onto the floor. The Administrator replied, Right, the sprayer nozzle was fixed. The following morning, the Administrator was asked for a copy of the policy which contained the proper disassembling and reassembling instructions the staff were trained to follow for the daily maintenance of the dishwasher. The Administrator stated he did not know what they were referring to and that the dishwasher was a leased machine and that the staff were not trained to disassemble or reassemble. An interview was conducted with the facility's Dietitian on 06/18/24 at 5:50 PM. She stated part of her responsibility as dietitian was to conduct weekly and monthly kitchen tours during which she ensured the equipment was maintained properly and that the kitchen was maintained in a clean manner. When asked if the facility's administration had explained to her the areas of concern in the kitchen, she stated they only told me there was a concern that some soapy water was found in a bowl that had just come out of the dishwasher. She stated she was unaware of additional concerns but that she would begin giving in-services to the staff. During a tour of the kitchen conducted on 06/19/24 at 9:45 AM, Staff E, Dietary Aide, was observed at the sink using the sprayer nozzle to clean dishes. Closer inspection revealed white tape had been used to wrap the hose of the sprayer nozzle. Additionally, white tape had also been used to wrap the pipe under the sink. Staff E stated the floor in the room was significantly dryer since the hose and pipe had been patched but that they were still leaking some. During this observation, it was observed that there were blue plastic curtains which hung down from each side of the dishwasher. The surveyor also observed dish racks with stabilizing posts were being used for the dishes and that the dishes being removed appeared to be clean. Kitchen refrigerator and freezer An initial tour of the facility's walk-in refrigerator was conducted with the Kitchen Manager on 06/17/24 at 12:18 PM. Upon entering the walk-in refrigerator, it was observed that there was a large amount of water on the floor of the refrigerator and condensation build up on all containers in the refrigerator. It was also observed that the inner handle of the refrigerator door was broken and had come loose from the inside of the door. There was a large buildup of a black substance on the floor. It was also observed that a broken thermometer was mounted on an inner wall of the refrigerator. (continued on next page)

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F 0908

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The Kitchen Manager was asked if this was the thermometer the staff used to check the refrigerator's temperature daily. The Kitchen Manager stated this was the thermometer the staff used. The Kitchen Manager was shown that the thermometer was broken, missing approximately a half an inch of glass from the middle of the thermometer. She then stated there was a different thermometer that was used but she did not know where it was located within the refrigerator. Further inspection of the refrigerator revealed a thermometer that had fallen off a shelf next to the door. This thermometer stated the temperature in the refrigerator was 60 degrees F.

Upon entering the walk-in freezer, located at the back of the walk-in refrigerator, the surveyor tripped over a buildup of ice on the floor on the inside of the freezer door, approximately 1.5 inches tall. The Kitchen Manager stated the buildup of ice had been there for some time. It was observed that there was a large build up of ice on the ducting and wiring of the cooling mechanism fan. The temperature in the freezer was 10 degrees F.

The Kitchen Manager stated that the staff had been entering and exiting the refrigerator and freezer as they had recently finished lunch service. She stated it was very warm in the kitchen that day and that the refrigerator had trouble keeping its temperature when the temperature was warm. When asked how long this had been a concern, she stated it had been an issue for over a year. She stated she had spoken to the administration about her concern in the past but that nothing had been done.

While touring the kitchen, there was a chest/reach-in refrigerator which contained cartons of milk. The temperature inside the refrigerator and the cartons of milk did not feel cool to the touch. The surveyor asked the Kitchen Manager if the thermometer on the outside of the refrigerator worked and was accurate, she stated it was not and that external thermometers were rarely accurate and were not used. When asked where the thermometer was inside the refrigerator, she stated she did not know. Further observation revealed there was no internal thermometer present inside this refrigerator.

A second tour of the walk-in refrigerator was conducted on 06/17/24 at 12:38 PM. During this observation, the temperature was 50 degrees F.

An interview was conducted with the District Kitchen Manager on 06/18/24 at 12:05 PM. He stated, as the district manager, he oversaw all tasks that fell under the realm of the kitchen. He stated he had not been aware of a refrigerator concern but that they had called a company to perform maintenance on the refrigerator to ensure it was in proper working condition.

A tour of the walk-in refrigerator was conducted on 06/18/24 1:25 PM. During this observation, the surveyor found three thermometers present, each reading 40 to 41 degrees F.

An interview was conducted with the facility's Dietitian on 06/18/24 at 5:50 PM. She stated part of her responsibility as dietitian was to conduct weekly temperature log checks of the refrigerator and freezer. She said she was not aware of concerns about the refrigerator's ability to keep a consistent temperature during warm weather.

The surveyor asked the District Kitchen Manager to review the work orders for the walk-in refrigerator/freezer-no work orders from prior to the survey exit were provided.

Pantry ice machines/refrigerators

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A tour was conducted on 06/17/24 at 4:30 PM of the facility's pantry rooms located on each resident care unit, three in total. In the pantry located on the 100-hall, a large ice machine was observed unplugged and not in service. There was a small refrigerator present in this pantry which contained a large buildup of ice along the back wall of the refrigerator, approximately 3 inches thick. In the pantry located on the 200-hall, a large working ice machine was observed. The surveyor noted the floor of the pantry was wet with water. Closer observation revealed the ice machine appeared to be the source of the water. It was found there were towels, a blanket, and paper towels under the ice machine along with dark gray/black biological build up under and behind the ice machine. While performing this observation, water was heard rushing from behind the ice machine. The surveyor observed water pouring out of a white L-shaped pipe that was located at the far back corner of the machine; this lasted approximately 10 seconds. Further observation in this pantry revealed a small refrigerator present which contained a large buildup of ice along the back wall of the refrigerator, approximately 3 inches thick and a large buildup of ice in the freezer compartment, approximately 1.5 inches thick. In the pantry located on the 300-hall, the surveyor observed a small refrigerator present which contained a large buildup of ice present in the freezer compartment, approximately 1.5 inches thick. The District Kitchen Manager explained that the facility's Plant Operations Manager was not present in the building, but that these areas of concern could be shown to the Plant Operations Manager that was overseeing the facility for the day. He explained this Plant Operations Manager was from a sister-facility in the area and had stepped in in the facility's Plant Operations Manager's absence. He further stated he and the kitchen staff were not responsible for overseeing the maintenance of the equipment found in the pantry rooms. A tour was conducted with the interim Plant Operations Manager on 06/17/24 at 4:50 PM. He stated he was not aware that the refrigerators and freezers were in need of de-frosting, that the one ice machine was not operational, or that the other ice machine was leaking. During the tour, the surveyor was able to show him the pipe that was leaking water. He stated that was likely a broken over-flow valve, which would be easy to fix. He stated he would tell the facility's Plant Operations Manager about these concerns. A tour was conducted on 06/18/24 at 8:42 AM of the facility's pantry rooms. The surveyor found no visible improvement in any of the identified areas of concern. A tour was conducted on 06/19/24 at 8:30 AM of the facility's pantry rooms. The surveyor found a new refrigerator present in the 100-hall pantry, but otherwise no visible improvement in the other identified areas of concern. During a facility-wide environmental tour conducted on 06/19/24 with the facility's Plant Operations Manager, these areas of concern were discussed. The surveyor asked if the interim Plant Operations Manager had told him about these areas of concerns, he stated he was not aware of these issues. The surveyor asked the District Kitchen Manager to review the work orders and maintenance logs for the refrigerators and ice machines. No work orders from prior to the survey entrance were provided. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Warewashing, revised date 02/2023 revealed the following: All dishware, serviceware, and utensils will be cleaned and sanitized after each use; The dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine. Review of the facility's policy titled Food Storage: Cold Foods, revised date 02/2023 revealed the following: All perishable foods will be maintained at a temperature of 41 degrees Fahrenheit (F) or below; An accurate thermometer will be kept in each refrigerator and freezer. Review of the facility's policy titled Equipment, revised date 09/2017 revealed the following: All foodservice equipment will be clean, sanitary, and in proper working order; All equipment will be routinely cleaned and maintained; All staff will be properly trained in the cleaning and maintenance of all equipment; Copies of service repairs and preventative maintenance reports will be submitted monthly. Review of the facility's policy titled Ice, revised date 10/2022 revealed the following: Ice will be prepared and distributed in a safe and sanitary manner; The Dining Services Director and/or Maintenance Director will ensure that all ice machines are plumbed from a potable water source and that air gap drains are appropriately maintained; The Dining Services Director will coordinate with the Maintenance Director to ensure the ice machines will be disconnected, cleaned, and sanitized quarterly and as needed.