

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Gueydan Memorial Guest Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Third St Gueydan, LA 70542	

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)
<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>44418</p> <p>Based on record review and interview, the facility failed to ensure residents' personal funds were available during non-banking hours. This failed practice had the potential to affect 51 residents who deposited funds in the residents' trust fund. The facility's total census was 51 with a census of 49 residents physically in the nursing home at the time of the survey.</p> <p>Findings:</p> <p>During a resident council meeting conducted with 4 (#8, #11, #24, #37) residents and S9ACT (Activities Director) on 08/05/2024 at 2:05 p.m., the residents were asked about personal funds and petty cash. Resident #24 stated they could not get petty cash on the weekend, and the other residents agreed. Resident #24 reported the only time residents could get cash was when the business office was open during weekdays not weekends. The residents present in the meeting all agreed, they were not aware they should have petty cash available to them at any time, including weekends.</p> <p>On 08/07/2024 at 8:37 a.m., an interview was conducted with S3SSD (Social Services Director), she reported she was responsible for resident's petty cash. S3SSD stated petty cash was only available to resident's Monday through Friday except for holidays. S3SSD confirmed petty cash was not available to residents on weekends when the business office was closed. S3SSD stated she was not aware petty cash needed to be available to resident at all times.</p>

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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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>44418</p> <p>Based on record review and interviews, the facility failed to ensure residents received mail on Saturdays. This had the potential to affect 49 residents residing in the facility.</p> <p>Findings:</p> <p>On 08/05/2024 at 2:05 p.m., during a resident council meeting, Residents #11, #24 and #37 each stated they do not receive their unopened mail on Saturdays. Residents #11 and #24 stated they only get their mail when the office is open Monday through Friday.</p> <p>On 08/07/2024 at 10:52 a.m., an interview was conducted with S4SEC (Secretary/Transportation Supervisor/Medical Record). She reported there was no one in the business office on Saturdays to deliver mail to residents. S4SEC stated the Saturday mail was delivered to residents first thing on Monday morning. S4SEC confirmed mail was not delivered to residents on Saturdays.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>44418</p> <p>Based on record reviews and interviews, the facility failed to ensure that their grievance policy and procedure was followed. The facility failed to ensure the residents and staff were aware of the procedure for filing grievances. The deficient practice had the potential to effect a census of 49 residents.</p> <p>Findings:</p> <p>Review of the facility's policy and procedure titled, Resident Care Grievance Policy, with a revision date of April 2017 and a review date of April 2023, revealed in part: Policy statement: all grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Policy interpretation and implementation: 2. upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations .5. The grievance officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. 6. The resident grievance/complaint investigation report form will be filed with the administrator within 5 working days of the incident. 7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within 3 working days of the filing of the grievance or complaint 10. Upon request, a copy of grievance must be given to the resident or representative.</p> <p>Review of facility's grievances from July 01, 2023 to July 31, 2024 revealed only 5 grievances had been filed. Each grievance had a complaint and action taken to solve section. Only 3 of the grievances noted the problem was solved. The other 2 complaints had no for problem solved and were greater than 5 days to be signed by Administrator.</p> <p>On 08/05/2024 at 2:05 p.m., during a resident council meeting, Resident's #8, #11, #24 and #37 each reported they did not know how to file a grievance or who to talk to about filing a grievance. Resident #24 stated residents were not aware if grievances were filed when complaints or issues are voiced. Resident #24 also stated residents do not get feedback or a written resolution when a complaint is reported as to what the resolution was.</p> <p>On 08/06/2024 at 11:17 a.m., an interview was conducted with S3SSD (Social Services Director), she confirmed she was responsible for the facility's grievances. She reported she was not sure of what all should be filed as a grievance. She stated usually S9ACT (Activities Director), would receive the initial complaints from the residents in the mornings, while serving them coffee. S3SSD stated when staff had their morning meetings, S9ACT would inform them of any complaints and administrative staff would review the concern and address. S3SSD stated a grievance/complaint was not completed because if there was a complaint the staff worked to get it resolved at the time. S3SSD again stated she did not know that resident complaints should be filed as a grievance. She confirmed the facility only had 5 grievances for the past year, as she was unaware of what should have been filed as a grievance.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44418</b></p> <p>Based on record review and interview, the facility failed to provide the resident and the resident's representative a written notice that specified the duration of the bed-hold policy for 1 (#102) of 1 (#102) residents investigated for hospitalization s in a final sample of 23 residents. This deficient practice had the potential to effect a census of 49.</p> <p>Findings:</p> <p>Review of the facility's policy titled, Bed-Holds and Returns, with a revision date of 04/2024, revealed in part: Policy statement: Resident and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. Policy interpretation and implementation: 1. all residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during period of absence (hospitalization or therapeutic leave). Residents are provided written information about these policies at least twice: a. well in advance of any transfer (e.g., in the admission packet); and b. at the time of transfer (or, if the transfer was an emergency, within 24 hours).</p> <p>Review of Resident #102's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses not limited to: Pneumonia, Hypoxia, Edema, Heart Failure and Anxiety. The resident's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 14, indicating the resident's cognition was intact.</p> <p>Review of the Ombudsman Notification of Transfer logs from May 2024- August 2024 revealed Resident #102's transfer dates as 05/17/2024, 06/08/2024, 07/19/2024, 07/22/2024 and 07/31/2024. Review of the column titled written notification to resident date revealed the date of the transfer. There was no further evidence provided that a written notification had been sent to the resident's RP (responsible party).</p> <p>On 08/06/2024 at 9:30 a.m., an interview was conducted with Resident #102, she stated she did not recall getting a letter/notice of a bed hold when she had gone out to the hospital.</p> <p>On 08/06/2024 at 9:52 a.m., an interview was conducted with S2DON/IP (Director of Nursing/Infection preventionist), she reported the facility does not send out letters for bed-hold when a resident goes out to the hospital. S2DON/IP stated S1ADM (Administrator) informed her that sending a bed-hold letter to the resident/RP was not necessary because the facility always had open beds. She also confirmed a letter was not sent to Resident #102 nor the RP when the resident was sent out to the hospital.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47354</b></p> <p>Based on observations, records reviews and interviews the provider failed to ensure that a resident's assessment accurately reflected the resident's status for 3 (#14, #28, #102) residents records reviewed out of a finalized sample of 23 residents as evidenced by:</p> <ol style="list-style-type: none"> <li>1. failing to ensure Resident #14's MDS (Minimum Data Set) assessment reflected dialysis;</li> <li>2. incorrectly identifying physical restraint use on Resident #28's MDS assessment; and</li> <li>3. failing to ensure Resident #102's MDS assessment reflected oxygen use.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Resident # 14</li> </ol> <p>A review of Resident #14's EMR (Electronic Medical Record) revealed an admitted [DATE] with diagnoses that included End Stage Renal Disease and Dependence on Renal Dialysis.</p> <p>A review of Resident #14's Physician's Orders, revealed and order dated 11/21/2022, that read in part, Dialysis on Monday, Wednesday and Fridays.</p> <p>A review of Resident #14's Quarterly MDS assessment dated [DATE], under Section O-Special Treatments, Procedures, and Programs; dialysis was not indicated.</p> <p>On 08/07/2024 at 12:42 p.m., a concurrent record review and interview was conducted with S5MDS (Minimum Data Set). S5MDS confirmed Resident #14 had an order for and received dialysis 3 times a week. S5MDS confirmed the 05/31/2024 MDS assessment failed to identify Resident #14 received dialysis and should have been indicated.</p> <ol style="list-style-type: none"> <li>2. Resident #28</li> </ol> <p>A review of Resident #28's EMR revealed an admitted [DATE] with diagnoses that included, Cognitive Communication Deficit, Dementia, and Primary Generalized Osteoarthritis.</p> <p>A review of Resident #28's Physicians Orders failed to reveal an order for physical restraints.</p> <p>Further review of Resident #28's Care Plan failed to reveal a problem or plan for physical restraints. There was no documentation found elsewhere in the resident's record that physical restraints were used.</p> <p>A review of Resident #28's Quarterly MDS assessment dated [DATE], under Section P-Physical Restraints; bed rail was indicated as used daily.</p> <p>On 08/05/2024 at 10:00 a.m., an observation was conducted of Resident #28 in her room. There was no evidence of any physical restraints.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/06/2024 at 9:50 a.m., a second observation was conducted of Resident #28 in her room. There was no evidence of any physical restraints.</p> <p>On 08/06/2024 at 10:00 a.m., a concurrent record review and interview was conducted with S5MDS. S5MDS viewed Resident #28's EMR and was unable to find any indications that physical restraints had been ordered or utilized. S5MDS confirmed the 5/30/2024 MDS assessment indicated that bed rails were used daily as a physical restraint and should not have been coded.</p> <p>44418</p> <p>3. Resident #102</p> <p>A review of Resident #102's EMR revealed an admitted [DATE] with diagnoses that included Pneumonia, Hypoxia, and Heart Failure.</p> <p>A review of Resident #102's Physician's Orders, revealed an order dated 06/24/2024, that read O2 (Oxygen) at 3L (Liters)/NC (per nasal cannula) continuously.</p> <p>A review of Resident #102's Quarterly MDS assessment dated [DATE], under Section O-Special Treatments, Procedures, and Programs; oxygen use was not indicated.</p> <p>On 08/06/2024 at 2:18 p.m., a concurrent record review and interview was conducted with S5MDS. S5MDS confirmed Resident #102's order for oxygen and had received it. S5MDS confirmed the 07/26/2024 MDS assessment failed to identify Resident #102 received oxygen and should have been indicated.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47354</p> <p>Based on observation, record review and interview, the facility failed to provide necessary care and services in accordance with professional standards of practice by failing to ensure oxygen was delivered at the ordered rate for 2 (#2, #102) out of 2 (#2, #102) residents investigated for respiratory care in a final sample of 23 residents.</p> <p>Findings:</p> <p>Resident #2</p> <p>A review of Resident #2's EMR (Electronic Medical Record) revealed an admitted [DATE] with diagnoses that included Pneumonia, Sepsis, and Dementia.</p> <p>A Review of Resident #2's Quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 06/18/2024 revealed she had a BIMS (Brief Interview for Mental Status) score of 03, indicating severely impaired cognition.</p> <p>Further review of Resident #2's August 2024 physician's orders revealed in part . Oxygen at 2L (Liters) per nasal cannula continuously with an order start date of 12/26/2023.</p> <p>On 08/05/2024 at 11:16 a.m., an observation was made of Resident #2 in the dining room with oxygen on and in place per nasal cannula. The oxygen setting was observed at 3L.</p> <p>On 08/07/2024 at 9:03 a.m., a second observation was made of Resident #2 in her bed with oxygen on and in place per nasal cannula. The oxygen setting was observed at 3L.</p> <p>On 08/07/2024 at 9:45 a.m., a record review and observation was made with S6LPN (Licensed Practical Nurse). S6LPN reviewed Resident #2's August 2024 physician's orders and confirmed the oxygen should be at 2L. She then observed Resident #2's oxygen setting. She confirmed the oxygen rate was incorrectly set on 3L and should have been on 2L as per the physician's orders.</p> <p>44418</p> <p>Resident #102</p> <p>Review of Resident #102's EMR (Electronic Medical Record) revealed an admitted [DATE] with diagnoses that included Pneumonia, Edema, Heart Failure, Tachycardia and Anxiety.</p> <p>Review of Resident #102's August 2024 physician's orders dated 06/24/2024 revealed O2 (oxygen) at 3 L/NC (liters per nasal cannula) continuous related to pneumonia.</p> <p>Review of Resident #102's MAR (Medication Administration Record) for August 2024 revealed O2 at 3L/NC continuously related to pneumonia.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #102's Care Plan revealed there was no Focus or Goal related to managing symptoms associated with Pneumonia nor was there an intervention including the continuous use of oxygen.</p> <p>On 08/06/2024 at 2:18 p.m., an interview was conducted with S5MDS (Minimum Data Set nurse). S5MDS reviewed Resident #102's care plan and confirmed the Focus of Pneumonia and intervention of continuous oxygen was not identified. S5MDS confirmed the use of oxygen at 3 L/NC should have been addressed on the care plan.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49176</p> <p>Based on record review, observations, and interviews, the facility failed to ensure residents who smoked were free from potential accidents and hazards, by failing to implement the facility's policy that required unsafe smokers to be provided a smoking apron for 3 (#36, #41 and #43) of 3 (#36, #41 and #43) residents who were care planned as unsafe smokers. The final sample size was 23 residents.</p> <p>Findings:</p> <p>On 08/07/2024, a review of the facility's smoking policy titled, Smoking Policy for Residents, with no documented revision date, read in part .Purpose: To assure that a resident desiring to smoke is allowed to do so in a manner and area which will not compromise his/her safety or that of others in this facility .Resident found to be unsafe smoker will be provided smoking apron and will be supervised by staff member while in smoke room .</p> <p>Resident #36</p> <p>Review of Resident #36's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease, Dementia, Major Depressive Disorder, Anxiety Disorder and Repeated Falls.</p> <p>Review of Resident #36's care plan read in part .is an unsafe smoker .04/28/2022. Resident will smoke only in designated areas and will not burn holes in furniture or clothing .Supervise resident at all times while smoking .08/21/2022 Re-assessed-Remains an unsafe smoker .</p> <p>Resident #41</p> <p>Review of Resident #41's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Dementia, Cognitive Communication Deficit, Depression, Muscle Wasting and Atrophy and Lack of Coordination.</p> <p>Review of Resident #41's care plan read in part .is an unsafe smoker .07/25/2022 .Will be supervised when smoking at designated times .</p> <p>Resident #43</p> <p>Review of Resident #43's electronic health record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease, Chronic Obstructive Pulmonary Disease, Asthma, Anxiety Disorder, and Major Depressive Disorder.</p> <p>Review of Resident #43's care plan read in part .is an unsafe smoker .12/21/2023 .will smoke only in designated areas and will not burn holes in furniture or clothing .Supervise at all times while smoking .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>08/05/2024 at 10:35 a.m., an interview was conducted with S2DON/IP (Director of Nursing/Infection Preventionist). She stated all five residents who smoke in the facility were considered unsafe smokers.</p> <p>On 08/07/2024 at 12:34 p.m., an observation was made of Resident #36, Resident #41 and Resident #43 in the smoking area smoking cigarettes. The residents were not observed wearing a smoke apron.</p> <p>S13CNASA (Certified Nursing Assistant/Smoke Aide) was observed monitoring the residents in the area.</p> <p>On 08/07/2024 at 12:35 p.m., an interview was conducted with S13CNASA. She stated that Resident #36, Resident #41, and Resident #43 were all unsafe smokers, but that the residents did not require an apron. All residents continued to smoke without an apron.</p> <p>On 08/07/2024 at 12:45 p.m., an interview was conducted with S2DON/IP. She stated that Resident #36, Resident #41 and Resident #43 were not required to wear a smoke apron even though all are considered unsafe smokers. The facility's policy, Smoking Policy for Residents was reviewed with S2DON/IP who confirmed policy stated resident found to be an unsafe smoker should be provided and wear a smoking apron.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>44418</p> <p>Based on record review and interviews, the facility failed to ensure an RN (Registered Nurse) was on duty for 8 consecutive hours per day 7 days per week. This deficient practice had the potential to affect all 49 residents residing in the facility.</p> <p>Findings:</p> <p>Review of Time Card Reports for RN hours from January 2024 through March 2024 revealed an RN did not work a total of 8 consecutive hours for the following dates in February 2024:</p> <p>02/19/2024 S2DON/IP (Director of Nursing/Infection Preventionist) had a clock-in time of 11:50 a.m. and clock-out time of 5:42 p.m. with 5.5 hours worked. No other RN had time on the time card reports.</p> <p>02/26/2024 S11RN had a clock-in of 5:29 a.m. and clock-out time 12:00 p.m., with 6.35 hours worked. S2DON/IP had a clock-in time of 6:57 a.m. and clock-out time 1:18 p.m. The facility's RN coverage totaled 7 hours and 48 minutes.</p> <p>Further review of time cards for March 2024 revealed no RN for had time documented on the time card report for March 10, 2024.</p> <p>On 08/07/2024 at 11:00 a.m., an interview was conducted with S2DON/IP as she reviewed the time card reports. S2DON/IP confirmed on 02/19/2024 and 02/26/2024 the facility did not have 8 consecutive hours of RN coverage.</p> <p>On 08/07/2024 at 2:45 p.m., an interview was conducted S4SEC (Secretary) who reported S10RN worked on 03/10/2024. S4SEC did not provided a time card report with the reported information by exit conference.</p>

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NAME OF PROVIDER OR SUPPLIER  Gueydan Memorial Guest Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 Third St Gueydan, LA 70542	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47540</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received a mechanically altered diet as ordered by the physician for 1 (#35) out of 6 (#2, #34, #35, #43, #44, and #102) residents reviewed for dining.</p> <p>Findings:</p> <p>Review of Resident #35's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Non-infective Gastroenteritis and Colitis and Dysphagia.</p> <p>Review of Resident #35's most recent Admission Minimum Data Set (MDS) dated [DATE] revealed the resident's Brief Interview for Mental Status (BIMS) score was 14, indicating her cognition was intact. Section K: Swallowing/Nutritional Status was checked for mechanically altered diet.</p> <p>Review of Resident #35's physician's orders revealed an order dated 06/24/2024 that read, NAS (No Added Salt) diet, Finely Chopped texture, Regular Consistency.</p> <p>On 08/05/2024 at 11:55 a.m. an observation was made of Resident #35's meal ticket and meal tray. Resident #35's meal ticket read in part, Finely Chopped. Observations of the meal tray served to the resident revealed 1 whole slice of meat loaf and 1 whole slice of garlic bread. Both items were not finely chopped.</p> <p>On 08/05/2024 at 11:57 a.m. an interview was conducted with S8RN (Registered Nurse). S8RN confirmed that Resident #35 was on a finely chopped diet as ordered by the physician and the items on her meal tray were not finely chopped.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47540</p> <p>Based on observations, interviews, and review of the facility's policy and procedures, the facility failed to maintain a clean and sanitary kitchen. This deficient practice had the potential to affect the 44 residents who consumed food from the kitchen. The facility's census was 49.</p> <p>Findings:</p> <p>On 08/05/2024, a review of the facility's policy titled, Fryer with no date of implementation or revision, read in part: After each use, fryer must be drained and thoroughly cleaned. The procedure to use is as follows: 1. Drain grease into thick container after cooled and dispose of .</p> <p>On 08/05/2024, a review of the facility's policy titled, Conventional Oven with no date of implementation or revision, read in part: Wipe oven doors, outside surface and racks with clean damp cloth . The porcelain interior can easily be cleaned with oven cleaners .</p> <p>On 08/05/2024, a review of the facility's policy titled, Pantry with no date of implementation or revision, read in part: . 2. dented can and spoiled foods should be disposed of promptly to prevent contamination of other foods .</p> <p>On 08/05/2024, a review of the facility's policy titled, Refrigerators and Freezers and Walk-in Cooler with no date of implementation or revision, read in part: . 3. Mop floors in walk-in refrigerators daily .</p> <p>On 08/05/2024, a review of the facility's policy titled, Labeling and Dating of Food Received with no date of implementation or revision, read in part: . Once opened, the product should be dated again with the date it was opened .</p> <p>On 08/05/2024, a review of the facility's policy titled, Dietary Services with no date of implementation or revision, read in part: . 2. Hair . cover the hair completely .</p> <p>On 08/05/2024, a review of the facility's policy titled, Ingredient Bins with no date of implementation or revision, read in part: . 6. Scoops used in bins are not to be left in the bin. Scoops are to be kept covered in a protected area conveniently located near the bins.</p> <p>On 08/05/2024 at 8:26 a.m. and initial tour of the kitchen was conducted with S7DM (Dietary Manager). S12CH was observed walking around the kitchen and cleaning the dishes with his beard exposed and not covered.</p> <p>On 08/05/2024 at 9:20 a.m. a second observation was made of S12CH walking past the prep station where food is being prepared for lunch with his beard exposed and not covered. Continued observations of the kitchen with S7DM revealed the following:</p> <p>1. Equipment:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A. Food residue noted on the kitchen fryer.</p> <p>B. Dark black grease noted in the kitchen fryer.</p> <p>C. Build-up of brown substance noted on the outside of the deep freezer.</p> <p>D. Build-up of debris and brown substance inside of the convention oven and the inside of the oven doors.</p> <p>2. Food storage:</p> <p>A. Refrigerated items:</p> <p>1. A chicken base container not labeled with the date it was opened.</p> <p>2. A bag of cheese with multiple areas of black spots noted to the cheese and packaging indicated it was spoiled.</p> <p>B. Dry Storage:</p> <p>1. Two dented canned goods in the dry storage room.</p> <p>2. A bag of pasta not labeled with the date it was opened.</p> <p>C. Walk-in Refrigerator:</p> <p>1. Pitcher of soda not labeled with the date it was prepped.</p> <p>2. Food residue and debris noted on the floor.</p> <p>D. Main Kitchen:</p> <p>1. A container of vanilla flavoring not labeled with the date it was opened.</p> <p>2. A bottle of soda flavoring not labeled with the date it was opened.</p> <p>3. A container of cream potatoes not labeled with the date it was prepped.</p> <p>3. S12CH (Cook Help) without a beard restraint while in the kitchen.</p> <p>4. A scoop noted inside of cereal container.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 08/05/2024 at 1:45 p.m. an interview was conducted with S7DM. S7DM confirmed the findings listed above throughout the kitchen tour. She stated if food items are opened or prepped by staff they must be labeled with the open or prep date. She stated if there are any discolored spots noted on food and if there are dented cans in the pantry it should be discarded immediately. She confirmed the floors in the walk-refrigerator consisted of old food residue and floors should be swept and mopped daily she was unsure when it was last cleaned. She stated that no scoops should be inside any containers they should be stored on the outside of the containers in their designated area. She confirmed the fryer should have been cleaned and the grease was dark and it should have been drained when it was last used on 08/04/2024. She stated the conventional oven consisted of debris and brown substance on the inside and brown substance was noted on the outside of the deep freezer and this should have been cleaned. She confirmed that S12CH should have had a beard covering on this morning while working in the kitchen.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47540</p> <p>Based on record review and interview, the facility failed to maintain an effective infection control and prevention program by failing to conduct yearly review of the infection program policies and procedures.</p> <p>Findings:</p> <p>On 08/06/2024, a review of the facility's policy titled, Infection Prevention and Control Program read in part: Policy Statement: An infection prevention and control program (IPCP) is established and maintained to prove a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . Further review revealed the policy was last updated on 10/2018.</p> <p>On 08/06/2024 at 9:56 a.m., an interview was conducted with S2DON/IP (Director of Nursing/Infection Preventionist). S2DON/IP stated that she was responsible for oversight of the infection control program. S2DON/IP failed to provide documentation when requested regarding when the facility's IPCP policies and procedures were last reviewed. S2DON/IP stated she was unaware that IPCP policies and procedures were to be reviewed annually.</p>