

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Cape Heritage Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 37 Route 6a Sandwich, MA 02563	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>49428</p> <p>Based on observation and interview, the facility failed to ensure resident rooms were maintained in good repair to promote a homelike environment on one of three units. Specifically, the facility failed to repair areas of chipped and loose textured ceiling, also known as popcorn ceiling, in five resident rooms in one out of three units.</p> <p>Findings include:</p> <p>During an observation with interview on 4/8/24 at 9:30 A.M., the surveyor observed several patches of popcorn ceiling missing from Resident #12's room in the area above the bed. Resident #12 said a storm caused water to leak from the ceiling causing areas of the popcorn ceiling to peel away and fall from the ceiling. Resident #12 said a piece of the popcorn ceiling fell and hit them on the head with no injury occurring. Resident #12 said the edges of the area where the popcorn ceiling was missing were peeling. Resident #12 said the remainder of the popcorn ceiling should be chipped away and repaired. Resident #12 said the ceiling had been in that condition for about three months and did not know why the facility had not yet made the repairs. Resident #12 said the ceiling situation was an issue. Resident #12 said the peeling ceiling was a hazard and someone could get hurt.</p> <p>During an observation with interview on 4/9/24 at 1:22 P.M., the surveyor observed several sizeable patches of the popcorn ceiling missing in Resident #8's room in the area above or adjacent to the Resident's bed. Resident #8 said the popcorn ceiling had been in disrepair since at least 10/31/23. Resident #8 said the remaining area adjacent to where the popcorn ceiling was missing was separating from the ceiling and the Resident wondered if any specks were going to fall down, particularly into their food.</p> <p>During an observation with interview on 4/9/24 at 3:30 P.M., the surveyor observed several sizeable areas of the popcorn ceiling missing in the room where Resident #51 and Resident #56 resided. Resident #51 and Resident #56 both said the missing patches of popcorn ceiling were unsightly, making the facility look old, and they would like the ceiling to be repaired.</p> <p>During an observation with interview on 4/7/24 at 9:30 A.M., the surveyor observed several areas of the popcorn ceiling missing in Resident #94's room. Resident #94 said they can see the areas of missing popcorn ceiling whenever they are in their room, and they would like the ceiling to be fixed.</p> <p>(continued on next page)</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation with interview on 4/7/24 at 3:00 P.M., the surveyor observed several sizeable patches of popcorn ceiling missing in Resident #88's room. Resident #88 said they did not like the missing patches of ceiling and would like for the facility to repair those areas.</p> <p>During an interview on 4/9/24 at 10:24 A.M., the Maintenance Director said he was aware of the loosening of the popcorn ceiling. The Maintenance Director said the maintenance department had chipped away as much of the loose popcorn ceiling as they could and were working on getting a vendor to make the repairs. The Maintenance Director said the Administrator was also aware of the ceiling situation on the unit.</p> <p>During an interview on 4/10/24 at 12:47 P.M., the Administrator said he was aware of the needed repair of the popcorn ceilings in the unit and was working to get the ceiling repaired.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46562</p> <p>Based on interviews, record review, and policy review, for one Resident (#66) of 21 sampled residents, the facility failed to ensure all alleged violations of abuse, neglect, exploitation, or mistreatment were reported to the Department of Public Health's (DPH) Health Care Facility Reporting System (HCFRS-a web-based system that health care facilities must use to report incidents and allegations of abuse, neglect, and misappropriation) as required. Specifically, for Resident #66, the facility failed to report alleged abuse by a visitor within the required timeframe.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Abuse, Neglect and Exploitation, dated 2/2023, indicated but was not limited to:</p> <p>-Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish it includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>-Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be an indication of noncompliance to the Federal requirements related to mistreatment, exploitation, neglect or abuse, including injuries of unknown source, and misappropriation of resident property.</p> <p>-The facility will have written procedures that include: reporting of all alleged violations to the administrator, state agency, adult Protective Services and to all other required agencies (e.g. law enforcement when applicable) within specified time frames: immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Resident #66 was admitted to the facility in July 2019 with the following diagnoses: dementia, diabetes mellitus, and post-traumatic stress disorder (PTSD).</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 2/13/24, indicated Resident #66 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15.</p> <p>Review of Resident #66's progress note, dated 3/25/24, indicated Resident #66 had reported to the social worker that on 3/24/24 his/her visitor had threatened to bash his/her head in if he/she did not produce the baseball cards that the visitor was demanding.</p> <p>On 4/9/24, review of the HCFRS failed to indicate that the facility had submitted a report for the alleged visitor to resident abuse that occurred on 3/24/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/9/24 at 9:50 A.M., the Director of Social Services said when the facility was made aware of the alleged violation the police were notified and a no trespass order was obtained. The Director of Social Services said Resident #66 had been worried and scared but was satisfied with the no trespass order. The Director of Social Services said when an alleged violation occurs it is reported to the administration team immediately.</p> <p>During an interview on 4/10/24 at 10:22 A.M., Unit Manager (UM) #1 said when a threat of harm was alleged the administration team was made aware so the allegation could be reported within the required timeframe.</p> <p>During an interview on 4/10/24 at 10:53 A.M., the Administrator said the alleged resident to visitor violation had been reported to the police immediately and the Resident's safety was ensured. The Administrator said the alleged violation had not been reported in HCFRS.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46562</p> <p>Based on observation, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, for residents on the [NAME] unit (a locked dementia unit), the facility failed to ensure psychotropic medication was secured and not accessible to residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Medication Storage Room/Medication Cart Policy, dated 2/2018, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Medications are stored primarily in a locked mobile medication cart which is accessible only to licensed nursing personnel. -Storage for other medications will be limited to a locked medication room. <p>On 4/8/24 at 1:37 P.M., on the [NAME] unit, where 28 of 30 residents were diagnosed with Alzheimer's/ dementia, the surveyor observed:</p> <ul style="list-style-type: none"> -Nurse #1 pop one Trazodone (antidepressant) 12.5 milligram (mg) tablet into a medication cup -Nurse #1 place the medication cup on top of the medication cart and walk down the hall to the nurses' station, leaving the medication cup on top of the medication cart outside of room [ROOM NUMBER] -Nurse #1 standing at the nurses' station with her back to the medication cart talking to Unit Manager #2 -Four residents standing around the medication cart with one of them resting his/her hand on the cart <p>During an interview on 4/8/24 at 1:56 P.M., Nurse #1 said she made a mistake and should not have left the prepared medication unattended on the cart.</p> <p>During an interview on 4/8/24 at 1:58 P.M., Unit Manager #2 said prepared medication should never be unattended.</p> <p>During an interview on 4/10/24 at 1:20 P.M., the Administrator and the Director of Nurses (DON) said prepared medication should not be unattended and accessible to residents.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428</p> <p>Based on observation, interviews, and test tray results, the facility failed to ensure each resident received food prepared by methods that conserve nutritive value, flavor, and appearance, and was palatable, attractive, and at a safe and appetizing temperature for two of two test trays.</p> <p>Findings include:</p> <p>During initial resident screening on 4/7/24, the survey team identified the following concerns expressed by residents about food palatability:</p> <ul style="list-style-type: none"> -Resident #8 said the food could be ice cold and could be improved. -Resident #88 said the food was sometimes not warm enough. -Resident #70 said the food was deplorable; the taste was not good and was usually not warm despite mentioning these concerns during previous food committee meetings. -Resident #38 said the food was always stone cold, especially the soup. The Resident said these things had previously been discussed at Resident Council. -Resident #45 said the food was terrible and cold all the time. -Resident #74 said sometimes the food temperature was not right. -Resident #53 said the food could be better, and sometimes it was cold. -Resident #1 said the food was not that great. The Resident said the food was served warm and was bland at times. -Resident #68 said the food was horrendous. The Resident said they sent the last five meals back to the kitchen. The Resident said they could not usually say anything good about the food, and they often ordered takeout from local restaurants. -Resident #43 said the food was terrible, low-grade. -Resident #47 said the food was not palatable, the flavor could use more salt and pepper. -Resident #1A said the food was not good in terms of texture, flavor, and visually. -Resident #55 said their family brought them food because they did not like the facility's food. -Resident #89 said the food was bland; temperature was warm. -Resident #20 said the mashed potatoes were watery, meat was overcooked, and hot food was served cold. The Resident said their friends bring them food. <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident #70 said the food had bad flavor and was usually not warm.</p> <p>-Resident #33 said the food was terrible; that it was cold with no flavor.</p> <p>Review of Resident Council Meeting Minutes, dated 3/21/24, indicated several resident concerns about:</p> <p>-cold breakfast.</p> <p>-cold soups.</p> <p>Review of Resident Council Meeting Minutes, dated 2/22/24, indicated several resident concerns about receiving cold food, especially breakfast.</p> <p>During Resident Council Meeting on 4/8/24 at 3:15 P.M., several residents said they had concerns with:</p> <p>-cold breakfast.</p> <p>-cold soup.</p> <p>On 4/8/24 at 1:00 P.M., the surveyor requested a lunch test tray to the [NAME] Unit. The food truck left the kitchen at 1:16 P.M., and arrived on the unit at 1:17 P.M. The test tray was conducted with the Food Service Director (FSD) obtaining temperatures at 1:35 P.M. with the following results:</p> <p>- Mixed vegetables: 124 Fahrenheit (F), cold, extremely soft, mushy texture, little flavor.</p> <p>- Baked dinner roll: 127 F, cold.</p> <p>- Baked lasagna: 152 F, very warm.</p> <p>During an interview on 4/8/24 at 1:00 P.M., the FSD declined to taste the contents of the lunch test tray. The FSD said the mixed vegetables were overcooked.</p> <p>On 4/9/24 at 8:30 A.M., the surveyor requested a breakfast test tray to the [NAME] Unit. The surveyor observed the food temperature log for breakfast that morning was not completed. The food truck left the kitchen at 8:32 A.M. and arrived on the unit at 8:33 A.M. The test tray was conducted with the FSD obtaining temperatures at 8:47 A.M. with the following result:</p> <p>-Omelet 123 F, lukewarm.</p> <p>-Hashbrown 123 F, lukewarm.</p> <p>-Orange juice in cup, 56 F, lukewarm.</p> <p>During an interview on 4/9/24 at 8:30 A.M., the FSD declined to taste the test tray. The FSD said breakfast tended to be the meal where most residents were concerned with temperature. The FSD said it was difficult to serve breakfast trays at the desired temperatures.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/10/24 at 9:47 A.M., the Dietitian said test tray meal temperatures have been mixed lately, with breakfast meals more consistently difficult to hold within the desired temperature range. Specifically, the Dietitian said the milk on Tuesday's test tray warm at 60 F.</p> <p>Review of Room Test Tray Evaluation forms indicated acceptable temperature ranges for food and beverage:</p> <ul style="list-style-type: none"> -Hot food items 135-160 F -Cold food items 40-55 F -Hot beverages 145-180 F -Cold beverages 40-55 F <p>Review of completed Test Tray Evaluation sheets indicated, but were not limited to, the following:</p> <ul style="list-style-type: none"> -4/8/24 Lunch: pulled pork sandwich entree 168 F prior to meal service, 134.2 F upon delivery; mixed vegetables 122 F upon delivery; ambrosia dessert 36 F prior to meal service, 87.6 F upon delivery; whole milk 60.6 F upon delivery. The Dietitian wrote all items were out of temperature range except for the coffee which is poured on the unit, and the vegetables were waterlogged. -3/12/24 Lunch: chicken entree 166 F prior to meal service, 128.5 F upon delivery; Spinach 167 F temperature prior to meal service, 128.3 F upon delivery. The Dietitian wrote the meal plate was lukewarm. -3/19/24 Lunch: fish entree 175 F prior to meal service, 112.3 F upon delivery; mashed potato 166 F prior to meal service, 124.7 F upon delivery; mixed vegetables 165 F prior to meal service, 106.1 F upon delivery. -3/21/24 Dinner: hot sandwich entree 160 F prior to meal service, 114.8 F upon delivery; French fries 164 F prior to meal service, 107.1 F upon delivery; coffee 142.4 F upon delivery; soup 125.1 F upon delivery; milk 58 F upon delivery. The Dietitian wrote the meal was tasty but unfortunately cold. -3/27/24 Lunch: chicken picatta entree 132.2 F upon delivery; spaghetti 122 F upon delivery; summer squash 133.3 F upon delivery; milk 60.7 F upon delivery; cottage cheese 56.2 upon delivery. -3/28/24 Breakfast: waffle 92.3 F upon delivery; sausage links 91.8 F upon delivery; oatmeal 176 F prior to meal service, 122.9 F upon delivery; milk 35 F prior to meal service, 56.5 F upon delivery. The Dietitian wrote the meal was too cold, with residents complaining the waffle was cold and hard and difficult to cut. -3/5/24 Breakfast: pancakes 119.1 F upon delivery; orange juice 35 F prior to service, 65 F upon delivery. The Dietitian wrote the pancakes were too cold, the plate was warm, not hot. The Dietitian also wrote the juice was too warm. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-1/26/24 Breakfast: scrambled eggs 160 F prior to service, 106.5 F upon delivery; orange juice 35 F prior to service, 60.5 F upon delivery. The administrator wrote the eggs were too cold and the orange juice was too warm.</p> <p>During an interview on 4/10/24 at 12:47 P.M., the Administrator said he has experienced issues with food temperatures when he completed Room Test Tray Evaluation forms, and he was aware of residents' concerns with food temperatures.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49428</p> <p>Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the main kitchen was maintained in a sanitary condition; 2. Ensure food items were properly labeled and dated in the main kitchen refrigerators; 3. Ensure food and drink items were properly stored, labeled, and dated in two of three kitchenettes; 4. Handle ready-to-eat food (food which does not require cooking or further preparation prior to consumption) utilizing proper hand hygiene to prevent cross-contamination (transfer of pathogens (biological contaminants) from one surface to another). In addition, to ensure the use of gloves was limited to a single use task; and 5. Utilize proper equipment cleaning and sanitation to prevent cross-contact (the inadvertent introduction of an allergen into a product that would not intentionally contain that allergen as an ingredient) during handling of ready-to-eat food. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the 2022 Food Code (model for safeguarding public health and ensuring food is safe for consumption) by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: <ul style="list-style-type: none"> 3-305.11 (A) Except as specified in paragraphs (B) and (C) of this section, food shall be protected from contamination by storing the food (1) in a clean, dry location. 6-501.12 (A) Physical facilities shall be cleaned as often as necessary to keep them clean. 6-501.14 (A) Intake and exhaust air ducts shall be cleaned and filters changed so they are not a source of contamination by dust, dirt, and other materials. <p>Review of the facility's policy titled Dietary Infection Control Policies, revised January 2011, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The facility must store, prepare, and distribute food under sanitary conditions. -The Dietary Department will be maintained in a clean and sanitary manner to prevent foodborne illness. <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 - Some</p>	<p>During an interview on 4/8/24 at 7:51 A.M., the FSD said he expected the dry storage shelving to be free of cobwebs and the kitchen floor to be clean and free of debris and food particles. The FSD said the ceiling vents and tubing should be free of dust as it could potentially contaminate work surfaces, equipment, and food.</p> <p>On 4/10/24 at 2:45 P.M., the FSD provided the surveyor with records of the Closing Check List for the main kitchen. Review of Closing Check List records showed the most recent documentation was on 1/12/24, on which date staff indicated they had swept and mopped the floors.</p> <p>During an interview on 4/10/24 at 9:47 A.M., the FSD said it appeared that staff were sweeping the open area of the dry storage room floor but not underneath the shelving.</p> <p>2. Review of the 2022 Food Code, revised January 2023, indicated but was not limited to the following:</p> <p>3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when packaging food using a reduced oxygen packaging method as specified under S 3-502.12, and except as specified in paragraphs (E) and (F) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit (F) or less for a maximum of 7 days. The day of preparation shall be counted as Day One.</p> <p>Review of the facility's policy titled Total Quality Management Program Dining Services Indicators, reviewed March 2011, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Food is stored properly. -Food is labeled and dated in the refrigerator and freezing and storage area. -Open items are wrapped or in an approved container, dated and labeled. <p>Review of the facility's policy titled Dietary Infection Control Policies, revised January 2011, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -All items stored in the refrigerator will be covered, labeled with the contents and the date. <p>On 4/7/24 at 8:03 A.M., the surveyor made the following food storage observations:</p> <p>A. Walk-in refrigerator in the main kitchen:</p> <ul style="list-style-type: none"> -One opened ham luncheon meat, no label or date. -One opened bag of pre-cooked meatballs, no label or date; the packaging was not securely closed and contents were exposed to air. -One opened container of cottage cheese, no label or date. <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 - Some</p>	<p>-Two plated side salads, wrapped, no label or date.</p> <p>-One open package of cubed potatoes, no label or date.</p> <p>-One open package of shredded cheese, no label or date.</p> <p>B. Dry storage room off the main kitchen:</p> <p>-Two bags of muffin mix, out of original box, no date.</p> <p>-One opened bag containing brown powder, no label or date.</p> <p>C. Outdoor walk-in freezer trailer:</p> <p>-One open box of omelets, no label or date.</p> <p>During an interview on 4/7/24 at 3:25 P.M., the Regional FSD said he expected any open boxes of product in the walk-in freezer to be labeled and dated.</p> <p>During an interview on 4/9/24 at 7:51 A.M., the FSD said any items removed from boxes should be labeled and dated. The FSD said the two bags of muffin mix in dry storage should be dated and the opened bag of brown powder should be labeled and dated.</p> <p>During an interview on 4/10/24 at 9:47 A.M., the Regional FSD said he expected any open food or drink items in the walk-in cooler to be labeled and dated with the date it was opened.</p> <p>3. Review of the facility's policy titled Personal Food Policy, undated, indicated but was not limited to the following:</p> <p>-Families and visitors of residents are permitted to bring food into the facility for the resident use. However, nursing home residents are at risk for serious complications from foodborne illness which may occur from unsafe food handling practices. In order to ensure the safety of our residents, food may only be brought into the facility in accordance with this policy.</p> <p>-The staff person receiving the personal food shall label the container with the date it was brought into the facility (or the date of preparation, if known) and the name of the resident receiving it.</p> <p>-Dietary aides are responsible for checking nourishment refrigerators daily and discarding any unused refrigerated food after three days.</p> <p>-Any perishable items that are found outside of the refrigerator or unlabeled shall be discarded unless it can be verified that the food has not been out for more than two hours.</p> <p>Review of the facility's policy titled Dietary Infection Control Policies, revised 1/2011, indicated but was not limited to the following:</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 - Some</p>	<p>-Foods brought into the facility by family members will be kept in appropriate storage, refrigerated if indicated, and discarded as appropriate. For example, prepared foods that require refrigeration should be discarded after 3 calendar days, whereas crackers stored in an airtight container may be kept longer.</p> <p>On 4/8/24 at 8:53 A.M., the surveyor observed in the [NAME] Unit kitchenette:</p> <ul style="list-style-type: none"> -One container of iced tea, opened with no resident label or date. -One container of thickened dairy beverage, opened, with no date. The manufacturer's label indicated to use within four days of opening. <p>On 4/8/24 at 4:52 P.M., the surveyor observed in the [NAME] Unit kitchenette:</p> <ul style="list-style-type: none"> -One container of iced tea, opened with no resident label or date. -One container of thickened dairy beverage, opened, with no date. The manufacturer's label indicated to use within four days of opening. -One plastic bag with a sandwich and bag of chips, no resident label or date. <p>On 4/10/24 at 7:42 A.M., the surveyor observed in the [NAME] Unit kitchenette:</p> <ul style="list-style-type: none"> -One container of iced tea, opened with no resident label or date. -One Styrofoam cup with straw, filled with liquid, no resident label or date. <p>During an interview on 4/10/24 at 7:42 A.M., Certified Nursing Assistant (CNA) #4 and CNA #7 said unit staff should label all food and drink with resident name and date when it was placed in the refrigerator. CNA #4 and CNA #7 said opened food or drink should be labeled and can be in the refrigerator for three days before being thrown away. CNA #7 said unit kitchen staff were responsible for monitoring dates and expiration dates of the food in kitchenettes.</p> <p>On 4/10/24 at 8:50 A.M., the surveyor observed the following in the [NAME] Unit kitchenette refrigerator:</p> <ul style="list-style-type: none"> -One pink water bottle, with no resident label or date. -one bottle of Vitamin Water, with no resident label or date. -one container of brown soup in Tupperware container, with no resident label or date. <p>On 4/10/24 at 9:12 A.M., the surveyor observed the following in the [NAME] Unit kitchenette refrigerator:</p> <ul style="list-style-type: none"> -one container of sour cream with room number, with no date; the manufacturer's expiration date was 3/25/24. <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 - Some</p>	<p>-one container of brown soup in Tupperware container, with no resident label or date.</p> <p>During an interview on 4/10/24 at 12:47 P.M., the surveyor observed the following in the [NAME] Unit kitchenette refrigerator:</p> <p>-one container of sour cream with room number, with no date; the manufacturer's expiration date was 3/25/24.</p> <p>-one container of brown soup in Tupperware container, with no resident label or date.</p> <p>During an interview on 4/10/24 at 12:47 P.M., the Regional FSD said the container of sour cream should be labeled with the resident's name and dated. The Regional FSD said the sour cream was past the expiration date.</p> <p>4. Review of the 2022 Food Code, revised January 2023, indicated but was not limited to the following:</p> <p>3-301.11 Preventing Contamination from Hands. (A) food employees shall wash their hands as specified under S 2-301.12. (B) Except when washing fruits and vegetables as specified under S3-302.15 or as specified in (D) and (E) of this section, food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.</p> <p>3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.</p> <p>Review of the facility's policy titled Dietary Infection Control Policies, revised January 2011, indicated but was not limited to the following:</p> <p>-All foods shall be prepared according to the FDA Food Code, with special attention paid to potentially hazardous foods. These include meats, poultry, stuffing, milk, dairy products, eggs, salads, cream-filled pastries, etc., and will be handled with extreme caution throughout the preparation and storage processes.</p> <p>-Handling of all food items during the preparation process will be minimized. This may be accomplished by using clean kitchen tools or by wearing clean gloves for each task.</p> <p>On 4/8/24 at 11:22 A.M., the surveyor observed Dietary Staff #1 making peanut butter and jelly sandwiches with no gloves on.</p> <p>On 4/8/24 at 12:26 P.M., the surveyor observed the FSD using visibly soiled oven mitts with gloved hands. The FSD returned to the tray line wearing the same gloves. The FSD was observed using the same gloves to grab handfuls of tossed salad to plate. The FSD was subsequently observed touching the tops of several resident lunch plates, buns, rolls, and tray line utensils while wearing the same gloves that handled the soiled oven mitts.</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 - Some</p>	<p>During an interview on 4/10/24 at 9:47 A.M., the Regional FSD said he expected Dietary Staff to take off gloves as soon as they leave a station, and for Dietary Staff to wash hands before entering a station. The Regional Food Service director said staff should use designated utensils for plating salad.</p> <p>During an interview with the FSD and the Regional FSD on 4/10/24 at 9:47 A.M., the FSD said the oven mitts had not been laundered in about 4 months. The Regional FSD said oven mitts could be an infection control issue.</p> <p>5. Review of the 2022 Food Code, revised January 2023, indicated but was not limited to the following:</p> <p>3-304.11 Food Contact with Equipment and Utensils. Food shall only contact surfaces of: (A) Equipment and utensils that are cleaned as specified under Part 4-6 of this Code and sanitized as specified under Part 4-7 of this Code.</p> <p>4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred.</p> <p>4-702.11 Before Use After Cleaning. Utensils and food-contact surfaces of equipment shall be sanitized before use after cleaning.</p> <p>On 4/8/24 at 12:46 P.M., the surveyor observed Dietary Staff #4 placing a peanut butter and jelly sandwich directly onto a prep table and re-using a knife to cut crust off the sandwich. Dietary Staff #4 was observed leaving the station without cleaning or sanitizing the prep table. Dietary Staff #4 left the used knife on the prep table.</p> <p>On 4/8/24 at 1:12 P.M., the surveyor observed the FSD placing a tuna salad sandwich on the same area of the prep table where Dietary Staff #4 prepared the peanut butter and jelly sandwich. The FSD was observed cutting the tuna salad sandwich using the same knife that cut the peanut butter and jelly sandwich. The FSD was observed leaving the station without cleaning or sanitizing the prep table.</p> <p>During an interview on 4/10/24 at 9:47 A.M., the Regional FSD said the prep table, where the peanut butter and jelly sandwich and the tuna salad sandwich were cut, should have been cleaned and sanitized after each use. The Regional FSD said Dietary Staff should have used a new knife to cut the tuna salad sandwich to prevent cross-contamination.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>46562</p> <p>Based on records reviewed, policy review, and interviews, for one Resident (#66), out of 21 sampled residents, the facility failed to maintain an accurate medical record in accordance with accepted professional standards and practices. Specifically, for Resident #66, the facility failed to ensure his/her weight was documented in the medical record as ordered by the physician.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Weights, dated 8/2015, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Weights are documented in the resident/patient's medical record and/or weight book <p>Resident #66 was admitted to the facility in July 2019 with the following diagnoses: dementia and diabetes.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 2/13/24, indicated Resident #66 had experienced a significant weight loss and was not on a prescribed weight loss regimen.</p> <p>Review of Resident #66's progress note, dated 2/9/24, indicated weights were trending down and his/her physician was made aware. The progress note indicated a new order had been obtained to weigh the Resident weekly for four weeks then monthly.</p> <p>Review of Resident #66's weight summary indicated:</p> <ul style="list-style-type: none"> -2/9/24 183.3 pounds -2/10/24 180 pounds -2/16/24 179.2 pounds -3/7/24 177.8 pounds -3/11/24 178.6 pounds <p>Further review of Resident #66's weight summary indicated no documented weights between 2/16/24 and 3/7/24, with 20 days between recorded weights.</p> <p>Review of Resident #66's February and March 2024 Treatment Administration Record (TAR) indicated he/she had been weighed as ordered on 2/24/24 and 3/2/24. The TARs did not include a numeric value to represent Resident #66's weight.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/24 at 10:22 A.M., Unit Manager (UM) #1 said the facility did not utilize a weight book and that weights were recorded on the resident's TAR or in the electronic medical record. UM #1 and the surveyor reviewed Resident #66's February and March 2024 TAR and electronic medical record and UM #1 said the weights had not been documented.</p> <p>During an interview on 4/10/24 at 1:20 P.M., the Director of Nurses (DON) said the expectation was for weights to be obtained and documented into the resident record as ordered.</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>46562</p> <p>Based on observations, interviews, and policy review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and potential transmission of communicable diseases and infections within the facility. Specifically, the facility failed to ensure staff adhered to infection control protocols for personal protective equipment (PPE) use when providing care and services to residents requiring precautions to prevent the possible spread of germs and illnesses.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Enhanced Barrier Precautions Policy, undated, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Enhanced barrier precautions require the use of gown and gloves for certain residents during specific high-contact resident care activities in which there is an increased risk for transmission of multi-drug resistant organisms. High-contact care activities include bathing/showering, providing hygiene, dressing, transferring, linen changes, toileting, device care and wound care. -Signage will be posted on the door or wall outside of the resident room indicating the need for enhanced barrier precautions, the required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves. <p>Review of the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precaution sign indicated but was not limited to:</p> <ul style="list-style-type: none"> -everyone must: clean their hands, including before entering and when leaving the room -providers and staff must: wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, wound care. <p>Review of the Centers for Medicare & Medicaid Services (CMS) circular letter, dated 3/20/24, titled Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) indicated but was not limited to:</p> <ul style="list-style-type: none"> -For residents for whom Enhanced Barrier Precautions are indicated, Enhanced Barrier Precautions is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing <p>On 4/8/24 at 1:49 P.M., the surveyor observed Certified Nursing Assistant (CNA) #2 at the foot of Resident #16's bed with one glove on and no additional PPE donned. CNA #2 was sorting linen and placing dirty linen in a bag. A CDC Enhanced Barrier Precaution sign was posted at the entrance of the room.</p> <p>(continued on next page)</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>During an interview on 4/8/24 at 1:52 P.M., CNA #2 said she was providing care to Resident #16 and changed him/her into a hospital gown.</p> <p>During an interview on 4/8/24 at 1:52 P.M., Nurse #1 said the Enhanced Barrier Precaution sign posted outside of the room was for Resident #16. Nurse #1 said the sign was for the Resident and not the staff because the Resident had a wound. The surveyor and Nurse #1 reviewed the Enhanced Barrier Precaution sign on the door and Nurse #1 said she would ask the Unit Manager to clarify the expectations.</p> <p>During an interview on 4/8/24 at 1:56 P.M., Unit Manager (UM) #2 said when a resident required Enhanced Barrier Precautions staff members providing high contact care should be using PPE as indicated on the sign posted outside of the rooms. UM #2 said CNA #2 should have worn gloves and a gown while providing care to Resident #16.</p> <p>On 4/9/24 at 8:46 A.M., the surveyor observed two CNAs shifting Resident #23 up in bed. The two CNAs were wearing gloves (no gown) and did not perform hand hygiene when leaving the room. A CDC Enhanced Barrier Precaution sign was posted at the entrance of the room.</p> <p>On 4/10/24 at 9:00 A.M., the surveyor observed CNA #4 feeding Resident #60. CNA #4 was observed using an ungloved hand to wipe something from the Resident's face. CNA #4 was observed touching her own face with an ungloved hand and opening the Resident's yogurt with both hands. The surveyor asked CNA #4 about the precautions required for Resident #60 and she said she was not sure and needed to check with the Nurse. Nurse #3 was also unsure if precautions were indicated. Nurse #4 confirmed at the nurses' station that Resident #60 did require Enhanced Barrier Precautions. CNA #4 then donned a gown and gloves but failed to tie the gown and properly secure it. A CDC Enhanced Barrier Precaution sign was posted at the entrance of the room.</p> <p>During an interview on 4/9/24 at 11:58 A.M., the Infection Control Nurse (ICN) said staff should follow the Enhanced Barrier Precautions signs as posted outside of the rooms. The ICN said everyone should perform hand hygiene prior to entering and when exiting the rooms and gowns and gloves should be worn when performing high-contact care activities.</p> <p>During an interview on 4/9/24 at 11:20 A.M., the Director of Nurses (DON) said staff should wear PPE when performing high-contact care as indicated on the signs posted outside of the rooms and all staff should perform hand hygiene when entering and exiting the rooms.</p>		

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<p>F 0921</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>46562</p> <p>Based on observations and staff interviews, the facility failed to ensure a functional, safe, and clean environment. Specifically, the facility failed to ensure residents and/or staff properly dispose of cigarette butts in designated smoking receptacles.</p> <p>Findings include:</p> <p>Review of the Centers for Medicare & Medicaid Services (CMS) circular letter, dated November 10, 2011, titled Smoking Safety in Long Term Care Facilities indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The Life Safety Code (NFPA 101, 2000 ed., 19.7.4) requires each smoking area be provided with ashtrays made of noncombustible material and safe design. -Metal containers with self-closing covers into which ashtrays can be emptied must be readily available. <p>Review of the facility's policy titled Smoking, dated as revised 11/2020, indicated but was not limited to:</p> <ul style="list-style-type: none"> -It is the policy of the facility to provide a healthy and safe environment for residents, staff and visitors by limiting the use of tobacco smoking materials on its campus -Purpose: to afford residents the privilege of smoking while maintaining a safe and clean environment within the policy of this facility, that also is respectful to the non-smoker <p>On 4/8/24 at 9:27 A.M. and 4:18 P.M., the surveyor observed the smoking area with a receptacle for cigarette butts but noted numerous cigarette butts on the pavement and scattered in the grass behind and around the smoking area.</p> <p>On 4/9/24 at 10:15 A.M., 1:16 P.M., and 4:14 P.M., the surveyor observed the smoking area with a receptacle for cigarette butts but noted numerous cigarette butts on the pavement and scattered in the grass behind and around the smoking area.</p> <p>On 4/10/24 at 7:04 A.M. and 10:09 A.M., the surveyor observed the smoking area with a receptacle for cigarette butts but noted numerous cigarette butts on the pavement and scattered in the grass behind and around the smoking area.</p> <p>During an interview on 4/8/24 at 4:18 P.M., Certified Nursing Assistant (CNA) #8 said residents were not allowed to smoke without a staff member present. CNA #8 said all cigarettes should be disposed of in the receptacle.</p> <p>(continued on next page)</p>		

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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 0921</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/9/24 at 10:15 A.M., CNA #3 said residents were provided four smoke breaks per day. CNA #3 said a staff member must be present with residents. CNA #3 said the cigarette butts should not be thrown on the ground and that all cigarettes should be extinguished and disposed of in the receptacle.</p> <p>During an interview on 4/10/24 at 2:29 P.M., the Maintenance Director said every morning the cement in the smoking area was swept to clean up the cigarette butts. The Maintenance Director said the grassy area around the smoking area was not often raked. He said cigarettes should be disposed of in the receptacle but every morning there was a lot to sweep up.</p> <p>During an interview on 4/10/24 at 1:20 P.M., the Administrator said the smoking area should be cleaned frequently and that cigarette butts should not be on the ground. The Administrator said the expectation was for cigarettes butts to be extinguished and disposed of in the receptacle.</p>		