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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A381	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Memorial District Hospital	35629 Highway 72 Salem, MO 65560

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47193 Reviewed AT Based on observation, interview, and record review, facility staff failed to follow professional standards when staff prepared four medication cups with medications prior to the timed medication pass and left one resident (Resident #10) medication unattended on top of the medication cart. Facility staff failed to notify three resident's (Resident #5, #7, and #13) physician regarding medications not being administered on time. The facility census was 18. 1. Review of the Facility's Administration of Drugs policy, dated 01/24/14, showed medications may not be prepared in advance and must be administered within one hour of preparation. 2. Observation on 09/25/24 at 10:10 A.M., showed the medication cart contained: -One medication cup labeled with a first name contained one pill; -One medication cup labeled with a first name contained eight various pills; -One medication cup labeled with a first name contained two various pills; -One medication cup labeled with a first name contained five various pills. During an interview on 09/25/24 at 10:10 A.M., Licensed Practical Nurse (LPN) A said the medications in the medicine cups were pre-popped for his/her morning medication pass. He/She said the medications are in his/her cart pre-popped while he/she is waiting for staff to get residents out of bed for the day. He/She said he/she cannot pass the medications while they are in bed because they are at risk for choking and he/she does not want to forget to pass them later. He/She said he/she is unsure what the facilities policy is on pre-popping medications. He/she said he/she has seen other staff pre-pop pills, so he/she believes it is okay. During an interview on 09/27/24 at 2:10 P.M., the Chief Nursing Officer (CNO) said the nurses should only be popping pills right before administration to each resident, and he/she expects the nurse to prepare medications for one resident at a time. During an interview on 09/27/24 at 2:26 P.M., the Unit Nurse Manager said he/she does not expect the nurses to practice pre-popping residents' medications. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 3:03 P.M., the Cheif Executive Officer (CEO) said he/she expects staff to prepare a resident's medications immediately before the scheduled time to administer the medication. 3. Review of the Facility's Medication Security policy, dated 03/01/14, showed: -All drugs and biologicals stored in this hospital shall be kept in a secure area, [NAME] when appropriate and accessible only to authorized personnel; -All drugs and biologicals, except those intended for crash carts use, will be stored in lockable containers or areas; -All medications at nurse stations shall be in lockable storage atv all times. Medications are stored either in lockable medicatioin carts/automated disensing machine or the medication room. 4. Review of Resident #10's Minimum Data Set (MDS), a federally mandated assessment tool, dated 07/22/24 showed staff assessed the resident as follows: -Severe cognitive impairment; -Used feeding tube; -Diagnosis of traumatic brain dysfunction. Observation on 09/25/24 at 10:54 A.M., showed LPN A prepared the resident's medication and left the medication cup on top of the medication cart unattended. Observation on 09/25/24 at 11:05 A.M., and 11:19 A.M., showed LPN A left the medication cart unattended and out of sight at the nurse's station as he/she went down the hall to a resident's room. Observation showed multiple residents seated at the nurse's station. During an interview on 09/26/24 at 5:33 P.M., LPN A said he/she placed the resident's medications in the cup of water on top of the cart so they could be dissolved before they were administered to the resident. The LPN said he/she must have stepped away from the cart to answer a call light or something like that, not realizing the medications were left unattended. The LPN said leaving the meds unattended on top of the cart created the risk of someone taking it, and he/she should have probably placed the cup in the top drawer of the cart when he/she stepped away from the cart. During an interview on 09/27/24 at 2:10 P.M., the CNO said it is not okay for staff to leave medications unattended on the cart or anywhere else, as it creates the risk for someone to take it. During an interview on 09/27/24 at 2:26 P.M., the Unit Nurse Manager said it is not okay for the nurse to leave medications unattended on the cart, due to the risk for someone such as a confused resident could get a hold of the medications and potentially take them. During an interview on 09/27/24 at 3:03 P.M., the CEO said staff should not leave medications unattended on the cart because staff could lose track of whose medication it is, someone could take it, or the medications could also be accidentally spilled. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the Facility's Medication error policy, dated May 2024, showed when a medication error is made and/or discovered by the nursing staff, the following steps are to be taken: -The patient is to be observed closely for any signs of adverse reaction; -The patient's physician is to be notified of the nature of the error; -An incident report is to be completed immediately by the person discovering the error, completed as thoroughly as possible and submitted to the nursing supervisor; -The error is to be charted in the patient's medical record, stating what was done wrong. 6. Review of Resident #5's annual MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment and Alzheimer's disease. Review of the resident's Physician Order Sheet (POS), dated September 2024, showed staff is directed to administer the following medications at 8:00 A.M.: -Levothyroxine (treat low thyroid) 100 microgram (mcg); -Tramadol (pain reliever) 50 milligrams (mg); -Aspirin (reduce the risk of heart attack) 81 mg; -Sennoside/docusate (treat constipation) 8.6/50 mg; -Multivitamin. Observation on 09/25/24 at 10:50 A.M., showed LPN A administered levothyroxine, tramadol, aspirin, sennoside/docusate, and a multivitamin to the resident. Review of the resident's medical record did not contain documention staff notified the resident's physician the resident's medication were administered late. 7. Review of Resident #7's admission MDS, dated [DATE] showed staff assessed the resident with mild cognitive impairment and dementia. Review of the resident's POS, dated September 2024, showed staff is directed to administer the following medications at 8:00 A.M.: -Pantoprazole (acid reducer) 40 mg; -Losartan (treat high blood pressure) 50 mg; -Isosorbide mononitrate (prevent chest pain) 30 mg; -Spironolactone (diuretic) 25 mg; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clonazepam (anti-anxiety) 0.25 mg; -Synthroid (treat low thyroid) 137 mcg at breakfast; -Plavix (blood thinner) 75 mg; -Sertraline (anti-depressant) 100 mg. Observation on 09/25/24 at 10:25 A.M., showed LPN A administered pantoprazole, losartan, isosorbide mononitrate, spironolactone, clonazepam, Synthroid, Plavix, and sertraline to the resident. Review of the resident's medical record did not contain documention staff notified the resident's physician the resident's medication were administered late. 8. Review of Resident #13's annual MDS, dated [DATE] showed staff assessed the resident with severe cognitive impairment and Alzheimer's disease. Review of the resident's POS, dated September 2024, showed staff is directed to administer the following medications at 8:00 A.M: -Furosemide (diuretic) 20 mg; -Florajen (probiotic). Observation on 09/25/24 at 12:00 P.M., showed LPN A administered furosemide and florajen to the resident. Review of the resident's medical record did not contain documention staff notified the resident's physician the resident's medication were administered late. 9. During an interview on 09/26/24 at 2:54 P.M., LPN A said the five rights of medication administration are to ensure the right patient, right medication, right route, right dose, and right time. The LPN said medications ordered to be given at 8 A.M. can be administered between 7 A.M. and 9 A.M., and if administered after 9 A. M., it would be considered a late administration, and maybe a med error. The LPN said if he/she made a med error, he/she thinks there is a form to be filled out, notify the Unit Nurse Manager, and maybe the doctor. The LPN said he/she did not notify the Unit Nurse Manager or the physician about the late medications because he/she just didn't even think about it. During an interview on 09/27/24 at 2:10 P.M., The CNO said he/she expects staff to follow the policy for Medication Administration, and if a nurse administered a medication after the allowed timeframe, that is considered a late administration and a med error. The CNO said if the nurse identified a med error occurred, he/she would expect the nurse to notify the Unit Nurse Manager/CNO, notify the physician of the error and obtain further directions from the physician on whether to administer the medication(s), or not. The CNO said if certain medications are administered late, it could increase the potential for a resident to have a negative outcome. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 2:26 P.M., the Unit Nurse Manager said if the nurse recognizes that medications will be administered late to a resident, or a medication error occurred, he/she would expect the nurse to notify him/her and notify the physician for further directions. During an interview on 09/27/24 at 3:03 P.M., the CEO said he/she expects staff to follow the facility's policies for medication administration, and if a medication is administered past the timeframe, it would be considered late. The CEO said the occurrence of a medication error would depend on the medication and what is stated in the policy. The CEO said if a medication error occurred, he/she would expect the nurse to document the reason for the late administration, alert the physician, CNO, and/or the supervisor at the moment.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39440 Reviewed AT Based on observation, interview, and record review, facility staff failed to obtain informed consent from the resident and/or resident representative for the use of side rails for one resident (Resident #5) and failed to complete an entrapment risk assessment or obtain a physician's order for use of the bed rails for five residents (Resident #5, #8, #11, #12, and #13), out of five sampled residents. The facility census was 18. 1. Review of the facility's policies showed staff did not provide a policy for Entrapment Risk Assessments. Review of the facility's Bed Rails Policy, dated 03/14/2014, showed bed rails are considered a restraint, three rails may be raised at one time to enhance bed mobility of the patient, all four rails may not be raised at the same time. Review of the facility's Consent for Use of Side Rails form, provided to each resident/resident representative at the time of admission, showed staff are directed to obtain a signed consent from the resident/resident representative, and obtain a physician's order including medical symptom/condition/diagnosis for use of the side rail (s). 2. Review of Resident #5's annual Minimum Data Set (MDS), a federally mandated assessment, dated 07/28/24, showed staff assessed the resident as: -Cognition not assessed; -Lower extremity impairment on both sides; -Required maximum assist from staff to roll left and right; -Dependent on staff for lying to sitting on side of bed, sitting to lying in bed. Review of the resident's medical record did not contain a signed consent from the resident and/or resident representative for the use of side rails, an entrapment assessment, or a physician's order for use of side rails. Observation on 09/26/24 at 11:10 A.M., showed the resident in bed on his/her right side with quarter rails on both sides in the upright position. During an interview on 09/27/24 at 10:14 A.M., the Unit Nurse Manager said he/she did not realize the resident's side rail consent form was not filled out or signed. 3. Review of Resident #8's quarterly MDS, dated [DATE], showed staff assessed the resident as: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Severe cognitive impairment; -No impairment to upper or lower extremities; -Required substantial/maximum assist from staff to roll left and right, lying to sitting on side of bed, sitting to lying in bed, and transfers from bed to chair. Review of the resident's medical record showed, the record did not contain an entrapment assessment or a physician's order for use of side rails. Observation on 09/26/24 at 11:12 A.M., showed the resident in bed on his/her left side with a quarter rail on the left side in the upright position. 4. Review of Resident #11's annual MDS, dated [DATE], showed staff assessed the resident as: -Cognition not assessed; -No impairment to upper/lower extremities; -Required substantial/maximum assist from staff to roll left and right, sitting to lying in bed, and transfers from bed to chair; -Dependent on staff for lying to sitting on side of bed. Review of the resident's medical record showed, the record did not contain an entrapment assessment or a physician's order for use of side rails. Observation on 09/26/24 at 11:12 A.M., showed the resident in bed on his/her left side with a quarter rail on the left side in the upright position. 5. Review of Resident #12's Admission MDS, dated [DATE], showed the staff assessed the resident as follows: -Moderate cognitive impairment; -Impairment on one side to upper/lower extremities; -Required substantial/maximum assist from staff to roll left and right, sitting to lying in bed, and transfers from bed to chair; -Stroke, Type 2 Diabetes and Hemiplegia (loss of strength to one side of the body) or Hemiparesis (inability to move one side of the body). Review of the resident's medical record showed, the record did not contain an entrapment assessment or a physician's order for the use of side rails. Observation on 09/25/24 at 2:30 P.M., showed the resident in bed with both quarter rails in the upright position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/26/24 at 9:00 A.M., showed the resident in bed with both quarter rails in the upright position. Observation on 09/27/24 at 11:30 A.M. showed the resident in bed with both quarter rails in the upright position. 6. Review of Resident #13's Annual MDS, dated [DATE], showed the staff assessed the resident as follows: -Cognition not assessed; -Required substantial/maximum assist from staff to roll left and right, sitting to lying in bed; -Dependent on staff for transfers from bed to chair and sit to stand; -Non-traumatic brain injury (damage to the brain by internal factors, such as lack of oxygen, exposure to toxins or pressure from a tumor). Review of the resident's medical record showed, the record did not contain an entrapment assessment or a physician's order for the use of side rails. Observation on 09/26/24 at 10:12 A.M., showed the resident in bed with one quarter rail in the upright position on. Observation on 09/27/24 at 9:00 A.M., showed the resident in bed with both quarter rails in the upright position. 7. During an interview on 09/27/24 at 11:35 A.M., the Activities Director (AD) said he/she is responsible to measure bed rails with mattresses quarterly, has been doing them for a few years, documents the measurements by bed serial number, and room number, but does not label the document with a resident's name. The AD said he/she does not do any measurements with a resident in the bed because he/she did not know that was required and was never taught to do that. The AD said he/she does not know anything about an entrapment assessment, he/she just measures the bed, the attached rails, and the mattress. During an interview on 09/27/24 at 2:15 P.M., the Chief Nursing Officer (CNO) said he/she was not familiar with entrapment assessments or consents for the use of bed rails/side rails. During an interview on 09/27/24 at 2:30 P.M., the Unit Nurse Manager said he/she did not know an order was needed for a side rail. The unit manager said he/she was not aware that an entrapment assessment needed to be completed for each resident. During an interview on 09/27/24 at 3:00 P.M., the Chief Executive Officer (CEO) said she was aware side rails typically need orders, but is not familiar with who has rails in the facility and who doesn't, so is not sure who has an order. The CEO said she believes it would be the nurse staff's responsibility to do entrapment assessments, consents and orders for each resident with bed rails/side rails but she does not know why they are not done. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	39644

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 47193 Reviewed AT Based on observation, interview, and record review, facility staff failed to maintain a medication error rate of less than 5% out of 25 opportunities observed, 15 errors occurred, resulting in a 60% error rate, which affected three residents (Resident #5, #7, and #13) out of seven sampled residents. The facility census was 18. 1. Review of the Facility's Medication Administration policy, dated 05/31/20, showed the individual administering a medication will be aware of the following information concerning each medication before administration: Appropriate timing of medication administration. 2. Review of Resident #5's Physician Order Sheet (POS), dated September 2024, showed staff is directed to administer medications at 8:00 A.M.: -Levothyroxine (treat low thyroid) 100 micrograms (mcg) daily on an empty stomach at 8:00 A.M.; -Tramadol (pain reliever) 50 milligrams (mg) twice daily at 8:00 A.M. and 5:00 P.M.; -Aspirin 81 mg daily at 8:00 A.M.; -Sennoside/docusate (treat constipation) 8.6/50 mg twice daily at 8:00 A.M. and 5:00 P.M.; -Multivitamin once daily at 8:00 A.M Observation on 09/25/24 at 10:50 A.M., showed Licensed Practical Nurse (LPN) A administered levothyroxine, tramadol, aspirin, sennoside/docusate, and a multivitamin to the resident (One hour and 50 minutes late). During an interview on 09/25/24 at 10:50 A.M., LPN A said he/she just passed the resident's morning medications because he/she was waiting for staff to get the resident out of bed. 3. Review of Resident #7's POS, dated September 2024, showed staff is directed to administer medications at 8:00 A.M.: -Pantoprazole (acid reducer) 40 mg daily at 8:00 A.M.; -Losartan (treat high blood pressure) 50 mg once daily at 8:00 A.M.; -Isosorbide mononitrate (prevent chest pain) 30 mg once daily at 8:00 A.M.; -Spironolactone (diuretic) 25 mg once dialy at 8:00 A.M.; -Clonazepam (anti-anxiety) 0.25 mg thre times daily at 8:00 A.M., 12:00 P.M., and 5:00 P.M.; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Synthroid (treat low thyroid) 137 mcg daily at breakfast; -Plavix (blood thinner) 75 mg daily at 8:00 A.M.; -Sertraline (anti-depressant) 100 mg twice daily at 8:00 A.M. and 8:00 P.M Observation on 09/25/24 at 10:25 A.M., showed LPN A administered the residents pantoprazole, losartan, isosorbide mononitrate, spironolactone, clonazepam, Synthroid, Plavix, and sertraline (One hour and 25 minutes late). During an interview on 09/25/24 at 10:25 A.M., LPN A said these medications were from the resident's morning medication pass. He/She said he/she was late to pass them because staff had not gotten the resident up out of bed during the morning medication pass. 4. Review of Resident #13's POS, dated September 2024, showed staff is directed to administer medications at 8:00 A.M.: -Furosemide (diuretic) 20 mg once daily at 8:00 A.M.; -Florajen (probiotic) once daily at 8:00 A.M Observation on 09/25/24 at 12:00 P.M., showed LPN A administered the residents furosemide and florajen (Three hours late). During an interview on 09/25/24 at 12:00 P.M., LPN A said the medications he/she has are from the resident's morning medication pass. He/She said he/she had late medications because the resident was not up out of bed during his/her medication pass. 5. During an interview on 09/26/24 at 2:54 P.M., LPN A said the five rights of medication administration are to ensure the right patient, right medication, right route, right dose, and right time. The LPN said medications ordered to be given at 8 A.M. can be administered between 7 A.M. and 9 A.M., and if administered after 9 A. M., it would be considered a late administration, and maybe a med error. The LPN said if he/she made a med error, he/she thinks there is a form to be filled out, notify the Unit Nurse Manager, and maybe the doctor. The LPN said he/she did not notify the Unit Nurse Manager or the physician about the late medications because he/she just didn't even think about it. During an interview on 09/27/24 at 2:10 P.M., the Chief Nursing Officer (CNO) said he/she expects staff to follow the policy for medication administration, and if a nurse administered a medication after the allowed timeframe, that is considered a late administration and a med error. The CNO said if the nurse identified a med error occurred, he/she would expect the nurse to notify the Unit Nurse Manager/CNO, notify the physician of the error and obtain further directions from the physician on whether to administer the medication(s), or not. The CNO said if certain medications are administered late, it could increase the potential for a resident to have a negative outcome. During an interview on 09/27/24 at 2:26 P.M., the Unit Nurse Manager said if the nurse recognizes that medications will be administered late to a resident, or a medication error occurred, he/she would expect the nurse to notify him/her and notify the physician for further directions. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/27/24 at 3:03 P.M., the Chief Executive Officer (CEO) said he/she expects staff to follow the facility's policies for medication administration, and if a medication is administered past the timeframe, it would be considered late. The CEO said the occurrence of a medication error would depend on the medication and what is stated in the policy. The CEO said if a medication error occurred, he/she would expect the nurse to document the reason for the late administration, alert the physician, CNO, and/or the supervisor at the moment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26A381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Memorial District Hospital	35629 Highway 72 Salem, MO 65560

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45564 Based on observation, interview and record review, facility staff failed to store food in a manner to prevent potential contamination and outdated use. Facility staff failed to reheat pureed food to prevent the growth of food-borne pathogens and potential for food-borne illness. Facility staff failed sanitize kitchen wares in a manner to prevent contamination. Facility staff failed to cover kitchen waste containers when not in actual use to deter the attraction of pests and rodents. These failures have the potential to affect all residents. The census was 18. 1. Review of the facility's Food Storage policy, revised [DATE], showed: -All food will have proper dates, labels and be properly covered when stored; -All prepared, ready-to-eat foods will be marked with a date of preparation and/or expiration date; -All food will be used by the expiration date. Review showed the policy did not address food storage on the freezer floor. 2. Observation on 09/25/24 at 10:41 A.M., showed the walk-in cooler contained opened and undated bags of brussels sprouts, lima beans, cubed potatoes, mixed vegetables, squash, corn nuggets, tater tots, and an unlabeled brown bag. 3. Observation on 09/25/24 at 10:44 A.M., showed the walk-in freezer contained: -A plastic zipper bag labeled pork and dated 7-24, which contained a frost covered substance; -Two plastic zipper bags labeled salmon patties and dated 7-11-24; -Four boxes of frozen foods set on the freezer floor. 4. Observation on 09/25/24 at 10:46 A.M., showed the reach in refrigerator contained a zipper bag of cooked bacon, two bags of shredded cheese and one bag of shredded carrots which were opened and undated. During an interview on 09/25/24 at 12:10 P.M., [NAME] B said the cook was responsible for checking the refrigerator and freezer daily. [NAME] B said all open food items should be labeled and dated. [NAME] B said all opened food items were good for three days after opening or preparation. [NAME] B said food should not be stored on the floor. During an interview on 09/26/24 at 8:00 A.M., the interim Dietary Supervisor (DS) said the cooks were responsible to ensure all food was labeled and dated. The interim DS said opened food items were good for three days. The interim DS said the cooks were responsible to put food deliveries away and food should not be stored on the floor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Salem Memorial District Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 35629 Highway 72 Salem, MO 65560	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of the facility's Pureed Diets policy, dated [DATE], showed the policy did not address pureed item preparation. Review of the facility's Food Temperatures policy, dated [DATE], showed: -The temperature of food items on trayline shall be taken and recorded before the start of serving; -Hot foods should be above 140 degrees Fahrenheit (F). If they are less than that, they must be returned for heating and reheated to greater than (>) 165 degrees F. 6. Observation on 09/25/24 at 11:22 A.M., showed [NAME] B pureed baked beans and added the beans to a bowl. [NAME] B covered the beans with a plastic lid and placed the bowl on the steam table. [NAME] B did not check the temperature of the beans after they were pureed. Observation on 09/25/24 at 11:30 A.M., showed [NAME] B added four hamburgers, beef broth and thickener to a food processor which was obtained from the drain board. [NAME] B pureed the items and separated the pureed food into four bowls. [NAME] B covered the bowls with plastic lids and placed the bowls on the steam table. [NAME] B did not check the temperature of the pureed hamburgers. Observation on 09/25/24 at 11:40 A.M., showed [NAME] B checked temperatures of steam table items but did not check the temperature of pureed items. Observation on 09/25/24 at 11:50 A.M, showed [NAME] B served residents pureed hamburgers and chicken noodle soup with crackers. Observation showed the temperature of the pureed hamburger was 95 degrees F when checked with a calibrated digital thermometer. Observation showed the temperature of the pureed chicken noodle soup was 125 degrees F. During an interview on 09/25/24 at 12:10 P.M., [NAME] B said he/she pureed items and placed them in covered bowls on the steam table. [NAME] B said he/she was never told to reheat pureed items so he/she never did. [NAME] B said he/she was aware the steam table was not acceptable method of reheating food. During an interview on 09/26/24 at 8:00 A.M., the interim Dietary Supervisor (DS) said hot foods should be held at 140 degrees F and served at 120 degrees F. The interim DS said he/she was not aware of specific requirements to prepare pureed foods. 7. Review of the facility's Nutritional Services Infection Control policy, undated, showed pots, pans, cooking utensils, etc. will be sanitized by an approved chemical per manufacturer's specifications. Review showed the policy did not address thermometer sanitization. Review of the sanitizer solution directions for use showed: -Scrape, flush or presoak articles to remove gross food particles and soil; -Rinse articles thoroughly with potable water; -Sanitize by immersing articles in a 150-400 parts per million solution for at least 60 seconds. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Observation on 09/25/24 at 11:25 A.M., showed [NAME] B hand washed the food processor parts, rinsed the items, placed the items in the sanitizer sink, swirled the items around in the sanitizer and did not fully submerge the items for one minute before he/she placed the items on the drain board to dry. Observation on 09/25/24 at 11:40 A.M., showed [NAME] B checked the temperature of the beans on the steam table. [NAME] B wiped the thermometer with an alcohol wipe, then wiped the thermometer with a red cloth which sat on the steam table. [NAME] B checked the temperature of the gravy, wiped the thermometer with an alcohol wipe, then wiped the thermometer with a red cloth which sat on the steam table. [NAME] B used the red cloth to wipe her gloved hands and placed the red cloth back on the steam table. [NAME] B checked the temperature of the hamburgers, wiped the thermometer with an alcohol wipe, then wiped the thermometer with a red cloth which sat on the steam table. [NAME] B used the red cloth to wipe her gloved hands and placed the red cloth back on the steam table. [NAME] B checked the temperature of fish, The cook used the red cloth to wipe her gloved hands and placed the red cloth back on the steam table. During an interview on 09/25/24 at 12:10 P.M., [NAME] B said all item should be completely submerged in the sanitizer solution for one minute. [NAME] B said he/she was nervous and he/she did not fully submerge the food processor. [NAME] B said he/she always used a cloth to wipe the alcohol from the thermometer. [NAME] B said he/she did not want to contaminate the food with alcohol and he/she did not know wiping the thermometer with the cloth was not acceptable. [NAME] B said he/she was nervous and did not realize he/she was using the cloth to wipe his/her gloves. During an interview on 09/26/24 at 8:00 A.M., the interim Dietary Supervisor (DS) said kitchen staff should follow manufacturer's instructions for sanitizer solutions. The interim DS said staff should not wipe a thermometer after it had been cleaned with alcohol. 9. Observation on 09/25/24 at 10:35 A.M. and 11:55 A.M., showed two large plastic trash cans, which contained kitchen wastes, not covered and not in use. Observation showed the area around the trash cans did not contain trash can lids. During an interview on 09/25/24 at 12:10 P.M., [NAME] B said the kitchen trash cans were purchased a couple weeks ago and did not have lids. [NAME] B said he/she was aware the trash cans should be covered when not in use. During an interview on 09/26/24 at 8:00 A.M., the interim Dietary Supervisor (DS) said he/she placed the new trash cans in the kitchen within the past week but they did not come with lids. The interim DS said the trash cans should be covered when not in use. During an interview on 09/26/24 at 8:00 A.M., the interim Dietary Supervisor (DS) said he/she was the hospital infection preventionist and he/she was filling in as DS. The interim DS said the facility had hired two different dietary supervisors in the past couple months, but neither stayed. The interim DS said the facility has a registered dietician who comes in two days per week and the previous dietary supervisor is currently working in another department. During an interview on 09/26/24 at 1:00 P.M., the Chief Executive Officer (CEO) said the facility was struggling to keep qualified staff. The CEO said he/she knew of some of the issues in the kitchen.

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 39644 reviewed AT Based on interview and record review, the facility staff failed to implement an effective Quality Assurance (QA)/Quality Qssurance Preformance Improvemnt (QAPI) program when staff did not meet and discuss interventions to correct any on-going systemic issues that pertain to the Long Term Care (LTC). The facility census was 18. 1. Review of the facility's LTC QAPI Policy, revised 06/16/22, showed the following: -To identify and correct quality deficits along the areas for improvement within Long Term Care; -The multidisciplinary team will meet monthly to evaluate a current projects and identify areas that need improvement or included. The LTC Medical Director will be made aware of the findings of the LTC QAPI Committee Monthly, LTC Director will report to the Hospital QAPI Committee quarterly. Review of the facility's records, showed staff did not provide documentation of a QAPI/QA program. During an interview on 09/27/24 at 2:16 P.M., the Chief Nursing Officer (CNO) said he/she is familiar with what the QA or QAPI process because the hospital side meets quarterly for this process, LTC is supposed to be included, but there is nothing specific to the LTC discussed. During an interview on 09/27/24 at 3:00 P.M., the Chief Executive Officer (CEO) said the Administrator/Executive Director would be responsible to have a QAPI/QA program implemented. The CEO said if there was a program previously, I do not know so we are starting from scratch.