STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345227	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Valley Cntr for Nursing and Rehabilitation	543 Maple Avenue Reidsville, NC 27320

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on staff interview, family interview and record review, the facility failed to clean and maintain resident rooms for 3 of 3 halls (Rooms A11, A15, A17, A19, A20, A21, A22, A25, B16, C12, C26) observed for cleanliness. The findings included: An initial tour observation was conducted on 6/17/24 at 10:00 AM-10:30 AM revealed several resident rooms and were observed on 3 of 3 halls the floors were sticky when walking across the floor, there was left over food, old paper cups, wrappers, straws, dingy, dirty brown matter, and stains in the floors. The corners and base boards of the rooms were embedded with dried food products, encrusted dirt and needed to be repaired. 1a. An observation was conducted on 6/17/24 at 10:00 AM, Room A11, the floors underneath nightstand was very sticky, with brown matter, old food/paper products on the floor. b. An observation was conducted on 6/17/24 at 10:05 AM, Room A15, the floor was stained and dirty, sticky, with old paper products and food under the nightstand and beside the closet. c. An observation was conducted on 6/17/24 at 10:07 AM, Room A17 a hole was in the baseboard of room near bed B, the baseboard was detached from the wall with broken and exposed sheet rock. The floor was dirty sticky, leftover cups, paper products and old food underneath, the nightstands. d. An observation was conducted on 6/17/24 at 10:09 AM, Room A19 the floor was sticky when walked across, underneath the bed and nightstand, there was a hole in the wall and baseboard coming apart from the wall. e. An observation was conducted on 6/17/24 at 10:10AM, room [ROOM NUMBER] the floor was very sticky, underneath the nightstand and bed there was left over food and paper products on floor. f. An observation was conducted on 6/17/24 at 10:12AM, Room A21 the floor was dirty, sticky and paper products were behind and underneath the nightstand. g. An observation was conducted on 6/17/24 at 10:14 AM, Room A22 floors dirty sticky, paper products behind nightstand,. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. An observation was conducted on 6/17/24 at 10:16 AM, Room A25 the floor was stained with brown matter, baseboard behind bed coming apart from the wall and the sheet rock was exposed. i. An observation was conducted on 6/17/24 at 10:16 AM, Room A29 the floor was dirty, sticky and stained with brown matter around baseboards, under nightstand and closet area. j. An observation was conducted on 6/17/24 at 10:18 AM, Room B16, underneath nightstand and under bed had leftover food and paper products. The floor was very dirty and sticky when walked across. k. An observation was conducted on 6/17/24 at 10:20 AM, Room B24 there was a hole in wall behind bed, leftover paper products and food was underneath nightstand and closet area. l. An observation was conducted on 6/17/24 at 10:21AM, Tomm C12 underneath the nightstand and around the closet area leftover food and paper products was on the floor. The floor was sticky, heavily stained with brown matter and dried liquids. m. An observation was conducted on 6/17/24 at 10:27 AM, Room C26, the baseboard coming apart from the wall and particles of sheet rock broken left on floor. An interview was conducted on 6/19/24 at 8:30 AM, the Housekeeper #1 stated due to staffing shortage she tries to complete as many rooms on her assignment as possible. She reported she was responsible for overall cleaning of the room, bathrooms, common areas, shower rooms, behind resident furniture, however, due to limited staff she cleans most critical areas and would get behind nightstands and in between closet, under beds when time allowed. She reported most of the time deep cleaning would include cleaning behind and under nightstands. An interview was conducted on 6/19/24 at 9:55, the Housekeeper #2 stated there were times when there were only two housekeepers, and she was unable to complete all the assigned rooms due to some rooms needed more attention than others. She reported that when her co-worker calls out the assignment increases, and she tries to do her best to clean as many rooms as possible. She further stated she may not be able to complete all the designated assignments on the daily checklist and/or deep cleaning list. She reported when there are 3 housekeepers scheduled it would normally be a deep cleaning day which throws the assignments off and if one-person doesn't show the assignment increase and we all try to clean the most critical areas. She reported she was responsible for cleaning under beds, under and behind nightstands/closets, however, time may not allow for the deep cleaning process. An observation and interview were conducted on 6/19/24 at 10:30 AM of the condition of resident rooms with the Maintenance Director who stated he started the position on 6/17/24. He stated he was not aware of all the environmental needs of the facility and planned to discuss any of the observations and concerns with the administrator and housekeeping supervisor. He was unaware of the current system in place to ensure repairs were completed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/19/24 at 10:50 AM, the Housekeeping Director who stated she was responsible for ensuring the housekeeping staff were maintaining the cleanliness of the environment. However, due to staffing issues she did not have the opportunity to follow up and observe whether the housekeeping staff were keeping up the cleaning schedules. She further stated two new housekeepers were hired and she would be stepping down from the role of the director. She further stated on a typical day there maybe 2 housekeepers 1 floor tech and 1 laundry staff most days. When there was a call out, she may have to step into the role of housekeeper, therefore she would be unable to follow-up behind the staff. An interview was conducted on 6/19/24 at 11:00 AM, the Floor Tech stated she worked 5AM-1PM and her responsibility was to empty trash, check and change curtains, buff/mop floors. She stated the second shift tech works 1PM-8:30 PM, she further stated housekeeping department has been short of staff for a while and they may not get to all resident rooms to deep clean, on a regular basis. She reported she tries to do as many rooms assigned on the schedule to the best of her ability. She reported if she was the only one working as a floor tech, she may not get to all the assigned rooms. An interview was conducted on 6/19/24 at 11:43 AM, the Administrator who stated the facility Environmental Service Director and Maintenance Director was responsible for ensuring the facility was clean and structural repairs were completed for the safety of all the residents. She stated resident room audits would be done based on the recent facility assessment. She indicated the Maintenance Director and additional housekeeping staff were recently hired on 6/17/24.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on staff interviews, and record review the facility failed to accurately code the Minimum Data Set (MDS) assessments in the area of cognitive patterns, and medication for 2 of 2 residents reviewed for resident assessment (Resident #251 and Resident #38). Findings included: 1. Resident #251 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm and tracheostomy status. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #251 had adequate hearing, no speech, and was usually understood. The Cognitive Patters section was not assessed and marked as the resident is rarely/never understood. The Staff Assessment for Mental Status was also marked as not assessed. During an interview on 6/19/24 at 11:55 AM, the MDS nurse indicated if any resident was unable to be interviewed for the cognition section, then the staff should be interviewed about the resident's cognitive status. She stated the cognition section should have been completed using staff interview and the resident's cognition status assessed appropriately. The MDS nurse indicated the cognition section should be completed for all residents. During an interview with the Administrator on 6/20/24 at 5:27 PM, she indicated it was her expectation that all MDS assessments were completed accurately. The MDS assessments should correctly reflect the resident's cognition status. 2. Resident #38 was admitted to the facility on [DATE]. A review of the medication orders for Resident #38 did not reveal she had been prescribed insulin injections. A review of the admission MDS assessment dated [DATE] indicated Resident #38 received an insulin injection on 1 of the 7 days during the look back period. During an interview on 6/19/24 at 11:55 AM, the MDS nurse stated Resident #38 received a Tuberculosis (TB) test (skin injection) upon admission. She indicated it had been an error to mark it as an insulin injection. During an interview with the Administrator on 6/20/24 at 5:27 PM, she indicated it was her expectation that all MDS assessments were completed accurately. The MDS assessments should correctly reflect the medications administered to the residents.

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on record review, family interview and staff interviews, the facility failed to implement an effective discharge planning process for 1 of 1 resident reviewed for discharge to the community (Resident #100). The findings included: Resident #100 was admitted to the facility on [DATE] with diagnoses that included right femur fracture, peripheral vascular disease, atrial fibrillation and chronic pulmonary obstruction disease. Resident #100's admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #100's cognition was intact. The resident needed one-person assistance with activities of daily living. Review of the discharge plan section of the admission MDS dated [DATE] asked the question whether active discharge planning already occurred for the resident to return to the community and the answer was no. There was no admission assessment completed. Care area assessment (CAA) from the admission MDS dated [DATE] did not trigger for discharge to the community. Review of the care plan dated 4/6/24 revealed there was no documentation for Resident #100's discharge plan to return to the community. Review of the notice of Medicare Non-Coverage revealed the service would end on 4/20/24. The notice was signed by Resident #100 on 4/18/24. A telephone interview was conducted on 6/20/24 at 5:34 PM and the family member stated she had been informed by the insurance company of the pending discharge date as 4/21/24. She further stated the facility did not discuss or schedule a discharge planning meeting at the time of admission or prior to discharge. She was unaware of the discharge process and was called on 4/19/24 by the facility to sign a discharge notice form. She could not recall who called her. The family member explained when she arrived on 4/21/24, the nursing staff on duty acted as though they were unaware Resident #100 would be discharged . She further stated there was no information provided at the time of discharge to include home health services, prescriptions for medication or instruction for home care. She further stated the nurse on duty told her she needed to call back on the morning of (4/22/24) for further instruction. She reported when she called back on 4/22/24, she returned to the facility to get Resident #100's prescriptions and was given a name and number to contact for a home health program. Resident #100 did not receive home health or therapy services for 3 weeks. The family stated she contacted the home health service to make the arrangements. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/20/24 at 6:00 PM with Nurse #9 who stated she worked on 6/21/24 and she was unaware Resident #100 was being discharged until the family arrived for pick-up. Nurse #9 reported the discharge paperwork had not been prepared or available for the discharge. She stated she was only able to provide the family with a medication list and a previously done history and physical assessment done by the nurse practitioner. She instructed the family to contact the facility in the morning for prescription orders and home health services. She stated the discharge process would have included an interdisciplinary meeting and all orders and services would be complied with a packet prepared by the social worker prior to discharge to be reviewed with the resident and family. Nurse #9 reported she was only able to provide what was available in the record. An interview was conducted on 6/19/20/24 at 10:45 AM with the Nurse Practitioner (NP) who stated Resident #100 was only in the facility for 18 days for rehab services. He stated there was no significant concerns or incident other than her rehab recovery. The Nurse Practitioner stated he did not do a discharge summary at the time of discharge. The nursing staff and social worker would prepare the paperwork and discuss resident community plans and services. He stated he saw the resident on 4/8/24, with knowledge the resident would return home at the completion of therapy. He stated the resident expressed a desire to return home during the assessment. He was unaware of the events of the discharge plan after that point Review of the physical therapy discharge summary dated 4/23/24 documented Resident #100 was seen by physical therapy for lower extremity therapeutic exercise for strength and balance with cues for techniques. The facility improved her standing balance reactions, ambulation with rolling walker in room with good progress. Resident #100 left the facility against medical advice. An interview was conducted on 6/20/24 at 3:52 PM, the Rehab Director stated Resident #100 was seen 4/4/24-4/19/24. She was admitted for rehab due to hip fracture. She stated the resident was independent with activities of daily living at the time of discharge and only needed lower body assistance but would need physical therapy in the home. She further stated a formal discharge meeting regarding the resident's progress or discharge plans for home care did not happen. She did not state why the meeting did not occur. The resident had discharged on the weekend. The Rehab Director did not respond to why the resident was listed as against medical advice An interview was conducted on 6/20/24 at 5:10 PM in conjunction with a record review with the Director of Nursing and revealed a discharge planning meeting with the resident, family and the interdisciplinary team had not taken place. The Director of Nursing acknowledged the facility did not implement the discharge process on admission and at the time of discharge. An interview on 6/20/24 at 4:43 PM in conjunction with a record review with the Admission staff revealed the discharge plan was not done on admission and at the time of discharge. She acknowledged the discharge plan was missed due to the absence of a social worker. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/20/24 at 4:43 PM in conjunction with a record review with the Administrator revealed all residents should have a discharge planning meeting on admission and prior to discharge with the resident and family. The interdisciplinary team was expected to meet prior to a scheduled discharge to discuss and prepare a packet of information of all the resident's orders with prescription medications and ensure the resident's home care needs were in place prior to the discharge. The record revealed there was no referral made to home health services prior to discharge to reflect Resident #100's healthcare needs at the time of discharge. The social worker would prepare the packet for the nursing staff prior to discharge. The discharging nurse would review the information with the resident and responsible person to ensure all services and instructions were in place at the time of discharge. The Administrator acknowledged due to the absence of a social worker the discharge process was not implemented in accordance with the facility policy. Moving forward, an audit of all discharges would be implemented immediately. The Administrator did not respond to why the resident was listed as against medical advice.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on record review and staff interview, the facility failed to complete a recapitulation of stay for 1 of 1 closed record reviewed for discharge to the community(Resident #100). The findings included: Resident #100 was admitted to the facility on [DATE] with diagnoses that included right femur fracture, peripheral vascular disease, atrial fibrillation and chronic pulmonary obstruction disease. Resident #100 admission Minimum Data Set(MDS) assessment dated 4/ 8 /24 coded Resident #100's cognition was intact. Resident #100 was discharged home on 4/21/24 and review of the record revealed the facility did not complete a recapitulation of stay. An interview on 6/20/24 at 4:43 PM, the Administrator stated a recapitulation of the stay would be completed by the interdisciplinary team to capture the full extent of the services provided to the resident during their stay. The Administrator acknowledged due to the absence of a social worker the discharge summary was not completed. She further stated nursing and social worker was responsible for ensuring the completion of the discharge summary. Moving forward, an audit of all discharges would be implemented immediately. An interview was conducted on 6/20/24 at 5:10 PM, in conjunction with a record review with the Director of Nursing revealed the discharge summary had not been completed. The Director of Nursing stated she was unsure why the facility had not completed the recapitulation of the resident's stay.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 41579 Based on record review and staff interviews, the facility failed to provide 8 hours of Registered Nurse (RN) coverage on 14 of 123 days reviewed. Findings included: Review of the PBJ (Payroll Based Journal) Staffing Data Report Fiscal Year - Quarter 2, 2024 (January 1-March 31, 2024) revealed the facility had no Registered Nurse (RN) coverage on 03/02/24, 03/09/24, 03/10/24, 03/24/24, 03/30/24, 03/31/24. Review of the daily assignment schedules from May 17, 2024, through June 17, 2024, revealed the facility failed to provide 8 hours of RN coverage on the following dates: 06/1/24, 06/9/24, 06/12/24, 06/13/24, 06/14/24, 06/15/24, 06/16/24, 06/17/24. During an interview with the Director of Nursing (DON) on 06/20/24 at 12:03 pm it was indicated staffing schedules were done by the Scheduler. She indicated when she first started working in the facility the facility had utilized agency staff, and as they were phasing out agency it was noticed they were having issues with RN coverage. On 06/20/24 at 4:38 pm an interview was conducted with the Scheduler, and she indicated she was aware of the requirement to have 8-hour RN coverage. She stated she tried to schedule RNs for 8 hours and the days that had no RN coverage a RN had been scheduled but they called out. An interview was conducted on 06/20/24 at 3:00 pm with the Administrator and she indicated it was her expectation that a RN would be in the facility 8 hours consecutively daily. She stated she was not made aware of the call outs from the Scheduler, and that she had informed her going forward that she needed to be informed if there was a RN coverage problem.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33778 Based on observations and staff interviews, the facility failed to date opened multi-dose insulin pen injections in 2 of 4 medication administration carts (Lower A hall and Lower B hall), failed to remove an expired multi-dose insulin pen injections in 1 of 4 medication administration carts (Lower A hall), and failed to discard loose pills in the medication administration cart drawer for 3 of 4 medication administration carts (Lower A hall, Upper and Lower B halls). Findings Included: 1. a. On 6/17/24 at 11:10 AM, an observation of the medication administration Lower A hall cart with Nurse #2 revealed one opened and undated multi-dose Lantus Glargine insulin pen injector, one opened Semglee Glargine insulin pen injector, one opened Humalog Lispro insulin pen injector, and one opened Basaglar insulin pen injector. A review of the manufacturer's literature indicated to discard Lantus, Semglee, Humalog and Basaglar insulin pen injectors 28 days after opening. On 6/17/24 at 11:20 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin pens in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift. b. On 6/17/24 at 11:25 AM, an observation of the medication administration Lower B Hall cart with Nurse #6 revealed one opened and undated multi-dose Novolog insulin pen injector. A review of the manufacturer's literature indicated to discard Novolog insulin pen injector 28 days after opening. On 6/17/24 at 11:35 AM, during an interview, Nurse #6 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift. 2. On 6/17/24 at 12:10 PM, an observation of the Lower A hall medication administration cart with Nurse #2 revealed one Aspart insulin flex Pen injector, opened on 5/10/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening (6/7/24); one Lispro Kwik Pen insulin injector, opened on 5/14/24. A review of the manufacturer's literature indicated to discard the insulin multi-dose vial 28 days after opening (6/11/24). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/24 at 12:15 PM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible for discarding expired multi-dose vials. The nurse stated that she had not checked the date of opening on insulin pens in her medication administration cart at the beginning of her shift. The nurse did not administer expired insulin this shift. On 6/17/24 at 12:30 PM, during an interview, the Director of Nursing (DON) indicated that all the nurses were responsible for putting the date of opening on multi-dose medication containers, checking all the medications in medication administration carts for expiration date, and remove expired medications every shift. She expected that no expired items to be left in the medication carts. 3. a. On 6/17/24 at 11:25 AM, an observation of the Lower B Hall medication administration cart with Nurse #6 revealed in the second draw of the medication cart, there were noted two white loose capsules, one blue round shape and one pink round shape loose pills. On 6/17/24 at 11:25 AM, during an interview, Nurse #6 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #6 did not clean the cart before her shift. b. On 6/17/24 at 1:30 PM, an observation of the Upper B Hall medication administration cart with Medication Aide #2 revealed in the second draw of the medication cart, there were noted four white loose round shape pills, two white capsules and one yellow round shape loose pills. On 6/17/24 at 1:35 PM, during an interview, Medication Aide #2 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Medication Aide #2 did not clean the cart before her shift. c. On 6/17/24 at 1:40 PM, an observation of the Upper A hall medication administration cart with Nurse #5 revealed in the second draw of the medication cart, there were noted two white loose round shape pills. On 6/17/24 at 1:45 PM, during an interview, Nurse #5 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #5 did not clean the cart before her shift. On 6/17/24 at 2:25 PM, during an interview, the Director of Nursing (DON) expected that no loose pills be left in the medication carts.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cypress Valley Cntr for Nursing and Rehabilitation	543 Maple Avenue Reidsville, NC 27320

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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** 38077 Based on observations, interviews and record reviews the facility failed to discard expired foods and label and date foods placed in the reach-in refrigerator, walk-in refrigerator and in the dry storage area. The facility failed to maintain the stove's backsplash, side of the stove, oven, deep fryer clean and free of grease, and failed to maintain the silverware holder containing clean silverware free of dried food. The facility failed to maintain the floors of the walk-in refrigerator, walk-in freezer and dry storage clean and free of dirt. These practices had the potential to affect food served to residents. Findings included: 1a. Observation of the reach-in refrigerator on [DATE] at 9 :18 AM, revealed a clean plastic container containing yellow colored food labeled Lemon pudding and 2 dates written on it [DATE] and [DATE]. A clear plastic container filled with cut fruit labeled Prep date [DATE] and Use by date [DATE]. A plastic container (Jug) one third filled with orange colored liquid with no lid or label on it. There were 18 cups containing fruit in a tray with no label or date on it. Two opened 42 fluid ounces (Fl. oz) carton labeled Thickened sweet tea with no open date. One opened 42 Fl. oz carton labeled Thickened orange juice with no opened date. A plastic container one fourth filled with reddish-purplish food labeled Jelly and dated [DATE]. During an interview on [DATE] at 9:18 AM, the dietary cook stated any leftover food should be discarded in 3 days or by the date indicated on the label. She stated the yellow-colored food was pudding, and the cut fruit was mixed fruit. She indicated that both these foods should have been discarded. The cook indicated the yellow-colored liquid was orange juice and should have been covered and labeled. The cook indicated she had not worked on the weekend and unsure when the tray was placed in the refrigerator. She indicated all food placed in the refrigerator should be labeled and dated. The thickened liquids when opened should be labeled and dated and should be discarded within 3 days. During an interview on [DATE] at 9:25 AM, the Dietary Manager indicated all thickened liquids when opened should be dated and discarded within 7 days. The Dietary Manager stated the thickened liquids were opened that morning ([DATE]) and staff had forgotten to date it. He stated all dietary staff were responsible to ensure the food was labeled and discarded appropriately. The DM stated the reddish-purple food was jelly used in making sandwiches and could be in the refrigerator for 10 days. 1 b. Observation of the walk-in refrigerator on [DATE] at 9:30 AM revealed a cardboard box containing 8 Fl. oz carton of 2 % milk with best by date [DATE]. There were thirty-two (32) carton of milk in the box. Observation also revealed one quart carton half and half with best by date [DATE]. A half-filled 2-liter soda bottled with no label. During an interview on [DATE] at 9:30 AM, the Dietary Manager indicated he was unsure why the expired milk and the half and half carton were still in the refrigerator. He indicated they received new boxes of milk carton earlier in the morning ([DATE]) and the expired box of milk should have been discarded. The Dietary Manager was unsure to whom the soda bottle belonged to and indicated staff should not be placing their personal food in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 c. Observation of the dry storage area on [DATE] at 9:35 AM revealed an opened plastic bottled, half filled with greenish colored food. The label on the bottle indicated Sweet relish and had an expiration date on [DATE]. Three (3) one gallon plastic containers labeled Pancake and Waffle syrup with date [DATE] on it. During an interview on [DATE] at 9:35 AM, the Dietary Manager indicated he had never seen these plastic containers and unsure when the expiration date of the syrup was. During an interview on [DATE] at 11:40 AM, the Regional Director for Environmental service and Dietary stated per vendor's email, if the syrup was stored in glass bottles it was good for 4 years and if the syrup was stored in plastic bottles it was good for 2 years from the date written on the containers. As the syrup was in plastic bottles, these bottles had to be discarded. 2 a. Observation of the reach-in freezer on [DATE] at 9:15 AM revealed ice and dried food on the floor of the freezer. During an interview on [DATE] at 9:15 AM, the dietary cook indicated she was not sure why the freezer was not cleaned. 2. b Observation of the walk-in refrigerator on [DATE] at 9:30 AM revealed pieces of paper (package paper and tape pieces) under the racks and red colored fluid puddle on the floor. During an interview on [DATE] at 9:30 AM the DM stated it was some accident that the dietary staff did not clean the refrigerator after they pulled the food out of the rack. He was unsure what the red colored fluid on the floor was. 2 c. Observation of the walk-in- freezer on [DATE] at 9:35 AM, revealed a greenish- bluish liquid on the floor. 4 big cardboard boxes of ice cream and a white colored cardboard box containing bags of frozen zucchini (unopened) on the floor. During an interview on [DATE] at 9:35 AM, the Dietary Manager indicated the ice cream boxes belonged to the activities department as the facility had celebrated Nurse Aides last week. The Dietary Manager indicated it was the responsibility of all dietary staff to ensure that the floor of the refrigerator or freezer were clean. 2 d. Observation of the dry storage on [DATE] at 9:40 AM revealed multiple pieces of packing paper, dust and dirt on the floor. The Dietary Manager indicated they received their supplies from their vendor earlier that morning. He further indicated that the dry storage floor was cleaned once a week after the supplies were stocked. 3a. Observation of the stove on [DATE] at 9:40 AM revealed the side of the cooking range and the back splash had blackish greasy stains. During an interview on [DATE] at 9:40 AM, the Dietary Manager stated the dietary staff cleaned the stove/range weekly and they had been working hard to get the grease stain out from the back splash. 3b. Observation of the oven on [DATE] at 9:40 AM and on [DATE] at 11:45 AM revealed dried brown stains on the inside of the oven door. Greasy, brown burnt stains were also observed on the racks and floor of the oven. The Dietary Manager stated the oven was used daily and cleaned only weekly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3c. Observation of the deep fryer on [DATE] at 9:40 AM revealed light brown oily stains in the front and side of the equipment. The Dietary Manager stated the deep fryer was cleaned once a week and he was responsible for cleaning the deep fryer. 3d. Observation of the steam table on [DATE] at 9:15 AM revealed a silverware holder containing clean silverware (forks, and spoon) having dried food particles and brownish colored fluid at the base of the holder. During an interview on [DATE] at 9:15 AM, the dietary cook indicated she was unsure why the silverware holder had the food particles and that it should be sent back to the dish washer to be washed again. 3e. Observation of the air-dry rack holding clean dishes on [DATE] at 9:15 AM and on [DATE] at 11;45 PM revealed a crate containing clean plates. There were multiple opened plastic bags containing plastic cup covers on these clean plates. During an interview on [DATE] at 9:15 AM, the dietary cook indicated staff should not be placing anything on the clean dishes rack while the clean dishes were air dried. She further stated the plates would be sent to the dishwasher to be washed and sanitized. During an interview on [DATE] at 11:45 AM the Dietary Manager stated the cup covers/ lids should not be placed on clean dishes. The plates would be sent back to the dishwasher to be washed again. Review of the document Weekly Game Plan AM/PM staff ,d+[DATE] - [DATE] indicated the names of staff that were responsible to clean the oven, dry storage room. Staff initials were on the side of the items they were responsible for cleaning, indicating it was clean by the assigned staff. The documents also indicated the Dietary Manager was responsible for cleaning the deep fryer and it indicated it was cleaned with his staff initial. Weekly cleaning document for 3 months were reviewed, and all documents had the initials of the staff indicating the assigned equipment was cleaned. During an interview on [DATE] at 3:00 PM, the Dietary Manager stated the dietary department had only weekly schedules and did not have any document that indicated daily schedules. All staff were responsible for cleaning after each task they had completed. During a reinterview with the Dietary Manager on [DATE] at 11:13 AM, he stated any leftover or prep food should be discarded within 7 days. The food should be labeled with a prep date and use by date and when by the use by date. The Dietary Manager stated opened thickened liquids should be labeled with open date and should be discarded within 7 days of opening. Regarding cleaning schedules, he indicated he had not been using daily cleaning schedules and followed only weekly cleaning schedule. For daily cleaning, the dietary staff were responsible to clean after themselves daily. He further indicated he was also responsible for cleaning the kitchen daily. The Dietary Manager stated he cleaned the deep fryer twice a week. The dietary staff cleaned and mopped the walk-in refrigerator three times a week. The dry storage was swept and mopped daily, and the dietary cooks were responsible. He indicated he was responsible for checking food in the walk-in and reach refrigerator and freezer and discarding any expired food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:24 AM the Regional Director for Environmental service and Dietary stated the Dietary Manager was provided with daily cleaning schedules and was unsure if it was appropriately followed. The weekly cleaning schedule was the deep cleaning schedule, and this should be followed by every dietary staff who have been assigned to the task. She further stated the Dietary Manager was responsible to ensure the daily cleaning and weekly cleaning schedule were appropriately completed by the staff. the Regional Director for Environmental service and Dietary stated the Dietary Manager should do a complete walk thoroughly of the refrigerator and Freezer and the kitchen twice a day. The food placed in the refrigerator should be labeled by the prep date and discard date and all staff would be educated on discarding food 7 days from the prep day. She indicated the thickened liquids should be dated when opened and discarded within 7 days. The racks used for clean dishes should always be holding only clean dishes. During an interview on [DATE] at 5:24 PM, the Administrator stated the Dietary Manager was responsible to ensure the cleaning schedules were followed by the dietary staff, ensure that all foods were labeled and expired food discarded. All equipment should be maintained clean and free of any grease and food particles. Both daily and weekly scheduled should be followed by all dietary staff. The Dietary Manager should be doing a walkthrough of the kitchen 2 times a day to ensure the areas were clean, expired food discarded and food was labeled appropriately.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 20906 Based on observations, staff interviews and record review, the facility failed to ensure the handrails in the facility corridors were properly secured to the walls, repaired and free from sharp edges on 3 of 3 halls where handrails were present. The findings included: An observation was conducted on 6/17/24 tour of facility 9:45 AM, revealed on the A hall the handrails were needed repairs due to broken/cracked and missing end caps in the corridor joining the A facility hall bathroom and rooms A1, A3, A6, A 11, A15, A17, A25, A26,28, A29 and the resident shower room on A hallway. The end of the handrails had sharp edges that were not covered by the endcaps. Staff and residents were observed using the handrails in the current condition. An observation was conducted on 6/17/24 at 10:00 AM, revealed on the C hall the handrails need repairs due to broken/cracked and missing end caps in the corridor joining the storage area between and room C27. An observation on 6/17/24 at 10:30 AM, revealed on the B hall the handrails needed to be repaired due to broken/cracked and missing endcaps in the corridor joining the B hall resident shower room, medical supply room, resident rooms B 7 , B16, B20, B21, and B25. A follow-up observation was conducted on 6/19/24 at 9:30 AM, revealed the identified handrails in the A hall, B hall and C hall remained in the same condition and had not been repaired. Staff and residents continued to use the handrails for support during mobilization on the units. An observation and interview were conducted on 6/19/24 at 10:30 AM with the Maintenance Director who stated he started the position on 6/17/24. He stated he was not aware of all the environmental needs of the facility and planned to discuss any of the observations and concerns with the administrator and housekeeping supervisor. He was unaware of the current system in place to ensure repairs were completed. An interview was conducted on 6/19/24 at 11:43 AM, the Administrator who stated the facility Environmental Service Director and Maintenance Director was responsible for ensuring the facility was clean and structural repairs were completed for the safety of all the residents. She included a handrail and resident room audits would be done for repairs and replacement immediately based on the recent facility assessment. She indicated the Maintenance Director and additional housekeeping staff were recently hired on 6/17/24.