

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Calcutta Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48444 Bell School Road Calcutta, OH 43920	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on observation, resident and staff interviews, record review, and facility policy, the facility failed to ensure Resident #251's right to attend an activity program was honored. This affected one resident (#251) out of 28 residents reviewed for choices. The facility census was 93.</p> <p>Findings include:</p> <p>Review of Resident #251's medical record revealed an admitted [DATE]. Diagnoses included nondisplaced intertrochanteric fracture of left femur, difficulty in walking, unspecified fall, acute kidney failure with tubular necrosis (kidney tubules are damaged or destroyed), and type two diabetes without complications, muscle wasting and atrophy (reduced muscle mass) , essential hypertension (high blood pressure), and weakness.</p> <p>Review of Inspira- Activities Initial Review, dated 06/03/24, revealed Resident #251's past activity interests included reading, crocheting, crossword puzzles, solitaire, and bingo, and the resident wished to participate in activities while in the facility.</p> <p>Review of Resident #251's care plan dated 06/03/24 revealed the resident was a new admit to the facility and needed opportunities for recreational programs similar to those at home. Interventions included the resident will adjust to the facility, routine, and peers through participation in group activities of choice similar to home, assist and reassure resident as needed, discuss activity preferences and allow choices, and invite, and encourage and assist to group programs of resident's choice.</p> <p>Further review of Resident #251's medical record revealed a progress note, dated 06/03/24, timed 7:13 P.M., and authored by Licensed Practical Nurse (LPN) #483, revealed the resident was uncooperative with treatment that shift and was refusing to lay down each time LPN #483 asked to apply dressing. The resident then became angry when LPN #483 stated she could not go to the activity at 6:30 P.M. until the dressing change was completed.</p> <p>Interview on 06/04/24 at 11:36 with Resident #251 revealed the resident was upset since she couldn't go to bingo the previous day since the nurse was changing her bandages. Resident #251 stated bingo was one of her favorite activities. Observation of Resident #251 at the time of interview revealed the resident appeared visibly upset.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/04/24 at 11:40 A.M. with Activities Staff #489 revealed Resident #251 had told the activity staff she had wanted to go to bingo on 06/03/24, but the resident ended up not attending the bingo activity since the nurse was changing her bandages.</p> <p>Interview on 06/04/24 at 4:24 P.M. with LPN#483 revealed Resident #251 had been noncompliant with having her dressings changed on 06/03/24. LPN #483 confirmed Resident #251 had wanted to go to bingo on 06/03/24 but LPN #483 told the resident she couldn't go to bingo until her dressing was changed. LPN #483 stated Resident #251 was upset about not being able to go to bingo, but LPN #483 didn't feel comfortable leaving the dressing change undone.</p> <p>Interview on 06/05/24 at 7:58 A.M. with Corporate Infection Control Preventionist #475 revealed LPN #483 should have educated Resident #251 of the importance of getting her treatments done, but Resident #251 does have the rights to refuse treatments and attend activities.</p> <p>Review of undated facility policy CHCC Companies Ohio Resident Rights & Facility Responsibilities revealed the residents have a right to have all reasonable requests responded to promptly and the right to participate in decisions that affect the resident's life.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>22653</p> <p>Based on observation, medical record review, review of protocols, and interview, the facility failed to ensure interventions/orders were implemented to protect resident's skin from injuries. This affected one (Resident #50) of three residents reviewed for non-pressure skin related impairments. The facility census was 93.</p> <p>Findings include:</p> <p>Review of Resident #50's medical record revealed diagnoses including Alzheimer's disease, stage three chronic kidney disease, and protein-calorie malnutrition.</p> <p>Review of a care plan initiated 11/24/21 indicated Resident #50 had a potential for alteration in skin integrity related to decreased physical mobility. Skin was fragile, bruised and tore easily. Interventions included applying geri-sleeves to both upper extremities to be on at all times except for bathing and hygiene.</p> <p>Review of a skin and wound evaluation dated 05/31/24 revealed Resident #50 had a skin tear on the right outer forearm which was acquired in the facility on 05/24/24. The skin tear measured 6.1 centimeters (cm) in length and 4.3 cm in width.</p> <p>Review of a physician order dated 09/30/24 indicated geri-sleeves were to be applied at all times but may be removed for bathing and hygiene. Check skin integrity under sleeves every shift.</p> <p>Observation on 06/04/24 at 10:29 A.M., 12:52 P.M. and 1:10 P.M., revealed Resident #50 was observed without geri-sleeves on either arm.</p> <p>Observation on 06/04/24 between 1:10 P.M. and 1:25 P.M., revealed Registered Nurse (RN) #478 was observed changing the dressing to a skin tear on Resident #50's right arm. Once completed, RN #478 pulled the right sleeve down over part of the dressing. Approximately the bottom 1/3 of the forearms were uncovered (with the exception of the area covered by the dressing).</p> <p>Interview on 06/04/24 at 1:25 P.M., with RN #478 revealed he did not know why Resident #50 did not have the geri-sleeves applied.</p> <p>Interview on 06/04/24 at 1:37 P.M., with Licensed Practical Nurse (LPN) #483 stated nobody had reported Resident #50 refused to have the geri-sleeves applied.</p> <p>Review of the facility's State tested Nursing Assistant (STNA) protocol revealed instructions to apply geri-gloves as ordered (on at rise and off at bedtime).</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015</p> <p>Based on observation, interview, and record review the facility failed to assist Resident #1 with applying her splint for her right-hand contracture. This affected one out (Resident #1) of two residents reviewed for limited range of motion. The facility census was 93.</p> <p>Findings include:</p> <p>Review of Resident #1's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's Disease, spastic hemiplegic cerebral palsy, and neuropathy.</p> <p>Review of Resident #1's quarterly minimum data set (MDS) assessment date 03/08/24 revealed the resident is cognitively intact and had an impairment on one side of her upper extremity (shoulder, elbow, wrist, hand).</p> <p>Review of Resident #1's GG Functional Abilities and Goals evaluation dated 03/08/24 revealed the resident is dependent for upper body dressing and lower body dressing.</p> <p>Review of Resident #1's June 2024 physician orders revealed an order dated 05/23/19 to monitor skin integrity of right hand every shift related to splint use.</p> <p>Review of Resident #1's Occupational Therapy (OT) Evaluation and Plan of Treatment form dated 08/09/22 revealed on 08/08/22 the resident was referred to OT due to Resident #1's right hand splint being reported as lost. Previous treatment included right hand splint to be applied from 8:00 A.M. through 12:00 P.M. Limitations included, functional limitations as a result of chronic right-hand contractor. Recommendations included continue right hands [NAME] with finger separators. The evaluation revealed the splint was located.</p> <p>Review of Resident #1's Care plan dated 03/14/24 revealed the resident had a plan of care for contracture's of her right hand/wrist. Interventions included a digit splint to right upper quadrant to be placed on at 8:00 A. M. and off at 12:00 P.M., monitor for proper position and body alignment, and monitor for signs of inflammation or swelling.</p> <p>Review the Resident #1's recent progress notes from 05/01/24 through June 06/03/24 revealed no mention of her right-hand splint.</p> <p>Observations on 06/03/24 at 11:11 A.M. and 06/04/24 at 10:52 A.M. revealed Resident #1 had an extensive contracture to her right hand. The resident did not have a splinting device on her hand.</p> <p>Interview on 06/03/24 at 11:11 A.M. Resident #1 revealed she was in therapy at one point for her right hand. She stated she is no longer receiving therapy services. The resident reported she does not have a splint for her right-hand contracture and denied staff asking her if she would like to apply a splint to her right hand.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/04/24 at 1:48 P.M. Licensed Practical Nurse (LPN) #508 reported that she assist with restorative nursing programs in the facility. She stated Resident #1 was on a restorative program to place a right-hand splint on the resident daily. LPN #508 reported the resident was removed from the restorative program and now it is the State tested Nursing Aides (STNA) responsibility to apply Resident #1's hand splint daily.</p> <p>Interview on 06/04/24 at 1:58 P.M. STNA #439 reports she is assigned to Resident #1 today. She reports she has not offered Resident #1 her splint and has not seen it recently.</p> <p>Interview on 06/04/24 at 2:07 P. M. with STNA #517 reported she the STNA for Resident #1. She reported she was not able to find the residents splint to apply it her. She reports she does not know how long it has been missing but she has not seen it in a while.</p> <p>Follow up Interview on 06/04/24 at 2:11 P.M. LPN #508 confirmed Resident #1 has not been offered her splint as ordered. She confirmed she was able to find it in the resident closet and will reeducate staff on assisting with applying the splint for the resident.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure the bag of tube feeding product was properly documented with the time and date of when hung as required. This affected one resident (#35) out of one resident reviewed for tube feeding but had the potential to affect four additional residents (#6, #30, #32, and #148) who received continuous enteral (a way of delivering nutrition directly to the stomach through a tube) feedings. The facility census was 93.</p> <p>Findings include:</p> <p>Review of medical record for Resident #35 revealed an admitted [DATE]. Diagnoses included cerebral palsy, severe intellectual disabilities, adult failure to thrive, unspecified protein-calorie malnutrition, pharyngeal phase dysphagia (difficulty swallowing), and abnormal posture.</p> <p>Further review of the medical record revealed a physician order dated 05/06/21 for NPO (nothing by mouth) diet and an order dated 04/19/24 for enteral feeding of Nutren 2.0 at 40 milliliter(ml)/hour continuous with 55 ml water flush continuous.</p> <p>Review of 05/24/21 care plan revealed Resident #35 required a feeding tube due to being NPO related to the diagnosis of dysphagia and received all nutrition/hydration via enteral feeding tube. Interventions included administer feeding via tube per physician order, monitor for tolerance to tube feeding and notify physician of any concerns, and assess pump for proper flow rate and check that equipment was functioning properly.</p> <p>Review of 03/06/24 annual Minimum Data Set (MDS) assessment revealed Resident #35 was severely impaired cognitively, dependent on staff for mobility, and received a tube feeding which provided 51 percent or more of his calorie needs and 501 cc/day of fluid was being provided either intravenously or by the tube feeding.</p> <p>Observation of Resident #35 on 06/03/24 at 11:43 A.M. revealed a bag of tube feeding product three fourth full labeled Nutren 2.0 with no documentation on the bag of the date or time of when the tube feeding had been hung. Interview at the time of observation with License Practical Nurse (LPN) #485 confirmed the bag of Nutren 2.0 tube feeding product for Resident #35 did not have a date or time documented on the bag of when the tube feeding product had been hung. LPN #485 stated the bag of tube feeding should have a date and time of when it was hung.</p> <p>Review of facility policy Enteral Feedings-Safety Precautions, revised May 2014, revealed it should be documented on the formula label the date and time the formula was hung/administered.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure communication between the facility and the dialysis center was being received after every dialysis treatment as required and weights were being completed as ordered. This affected one resident (#248) out of one resident reviewed for dialysis. The facility identified Resident #248 as the only resident receiving dialysis. The facility census was 93.</p> <p>Findings include:</p> <p>Review of medical record for Resident #248 revealed an admitted [DATE]. Diagnoses included type two diabetes mellitus, kidney transplant failure, end stage renal disease, hypertensive chronic kidney disease with stage five kidney disease, anemia in chronic kidney disease, hyperkalemia (high potassium levels in the blood), hypocalcemia (low calcium levels in the blood), and dependence on renal dialysis.</p> <p>Review of 05/15/24 admission/Medicare five-day Minimum Data Set (MDS) assessment revealed Resident #248 was cognitively intact, required substantial/maximum assistance from staff for transfer, and received dialysis.</p> <p>Review of the medical record for Resident #248 revealed an order dated an order dated 05/08/24 for hemodialysis three times a week M-W-F (Monday, Wednesday, and Friday) and an order dated 05/08/24 for Weight three times a week per hemodialysis.</p> <p>Review of care plan dated 05/28/24 revealed Resident #248 received dialysis three times a week. Interventions included prevent complications of renal insufficiency/failure through next review date, dialysis three times a week per schedule, and monitor for any changes in cardiac output, any changes in vital signs and skin and report to physician.</p> <p>Further review of care plan dated 05/28/24 revealed Resident #248 had a hemodialysis Tesio catheter (a type of catheter used for dialysis) in place and was at risk for infection due to indwelling Tesio catheter. Interventions included weigh three times a week per hemodialysis, monitor for signs/symptoms of bacteremia (bacteria in the blood) /septicemia (infection on the blood) such as fever, malaise (general feeling of discomfort illness, or fatigue), mental status changes post dialysis, and notify physician of any changes in condition as needed.</p> <p>Review of communication documents between the facility and dialysis uploaded into Resident #248's medical record revealed there was proof of written communication between the two facilities on 05/13/24, 05/15/24, 05/17/24, 05/27/24, 05/31/24, and on 06/03/24, and there was no proof of written communication between the two facilities on 05/10/24, 05/20/24, 05/22/24, 05/24/24, and 05/29/24.</p> <p>Review of Resident #248's weights in the medical record revealed the resident weighed 201.8 pounds on Wednesday 05/08/24, 206.0 pounds on Wednesday 05/15/24, 205.0 pounds on Tuesday 05/21/24, 208.0 pounds on Wednesday 05/29/24, and 208.0 pounds on Monday 06/03/24. There were no documented weights for Friday 05/10/24, Monday 05/13/24, Friday 05/17/24, Monday 05/20/24, Wednesday 05/22/24, Friday 05/24/24, Monday 05/27/24, and Friday 05/31/24.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #248's medical record revealed there was no documented reasons in the progress notes dated 05/08/24 (admitted) to 06/04/24 for weights not being obtained as ordered.</p> <p>Interview on 06/06/24 at 11:22 A.M. with Registered Nurse #497 confirmed there was an order for weights three times a week, and there were missing weights.</p> <p>Interview on 06/06/24 at 12:09 P.M. with Corporate Infection Preventionist (CIP) #475 confirmed all the documentation between the dialysis center and the facility had been uploaded into the medical record. CIP #475 confirmed the missing documentation between the dialysis center and the facility and went on to state the facility should receive documentation from dialysis center after each treatment. If the facility hadn't received the documentation from the dialysis center, they were to call the dialysis center. CIP #475 also confirmed weights for Resident #248 had not been obtained as ordered.</p> <p>Review of undated facility policy Physician Services revealed all physician orders would be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during the shift.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>49774</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on review of the Payroll-Based Journal Staffing Data Report (PBJ), review of staffing schedules, staff interviews, and review of a Facility Assessment, the facility failed to ensure adequate staffing ratios were maintained for the 4th Quarter of 2023. This had the potential to affect all 93 residents.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the PBJ report revealed excessively low weekend staffing for the 4th quarter of 2023 was an area of concern. Review of the staffing schedules for the nurses and State tested Nurse Aides (STNA) for October, November, and December of 2023 revealed the facility did not have consistent and adequate weekend staffing. Completion of the staffing tool revealed inadequate staffing levels for the following dates: 10/07/23 was at 2.10, 10/08/23 was at 2.42, 12/02/23 was at 2.37, 12/09/23 was at 2.45, and 12/10/23 was at 2.33. Interview on 06/04/24 at 2:16 P.M. with the Director of Nursing (DON) confirmed he was aware that staffing levels were lower than normal for the 4th quarter but was doubtful the facility was out of compliance. Interview on 06/06/24 at 11:35 AM with the Administrator confirmed the facility did not meet adequate staffing levels in the 4th quarter of 2023. <p>The deficient practice was corrected on 04/01/24 when the facility implemented the following corrective actions:</p> <p>Nurse aide training was offered at no cost</p> <p>A recruiter was hired to focus solely on recruitment efforts</p> <p>New hire sign on bonus and retention bonuses were implemented</p> <p>Wages were increased across all departments</p> <p>The facility decreased its bed capacity to 107 beds</p> <p>Tuition reimbursement was offered</p> <p>The facility based staffing levels on resident population and acuity</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 06/06/24 surveyor reviewed staffing schedules for the months of April, May and June of 2024 and confirmed adequate staffing levels were achieved and the facility was in compliance.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46195</p> <p>Based on observation, interview, and review of facility menu and spread sheets, the facility failed to ensure the menu was followed and correct portion sizes were served for lunch on 06/04/24 for residents on a mechanical soft diet. This affected 13 residents (#3, #5, #14, #15, #24, #28, #52, #58, #68, #75, #84, #90, and #346) out of the 14 residents who the facility identified as being on a mechanical soft diet. This had the potential to affect 89 residents who received meals from the kitchen. The facility identified four residents (#6, #32, #35, and #395) as receiving nothing by mouth. The facility census was 93.</p> <p>Findings include:</p> <p>Review of the resident choice meal for lunch on 06/04/24 revealed pizza pasta casserole, Prince [NAME] vegetable medley, and lemon strawberry fluff dessert would be served.</p> <p>Review of spread sheets for the lunch meal on 06/04/24 revealed both the regular and the mechanical soft consistency diets would receive eight ounces of the pizza pasta casserole, 4 ounces of the Prince [NAME] vegetable medley, and a half a cup of lemon strawberry fluff dessert. The puree consistency diets would receive two number eight (four ounces) scoops, one number eight scoop of puree vegetables, and one number eight scoop for the puree lemon strawberry fluff.</p> <p>Observation of the tray line on 06/04/24 from 11:56 A.M. to 12:33 P.M. revealed Dietary [NAME] #480 was serving one green handled (three and one fourth ounce) scoop of carrots for the mechanical soft diets.</p> <p>Interview on 06/04/24 at 12:03 P.M. with Dietary [NAME] #480 confirmed he had been using a green handled scoop for the carrots, which he had been serving to the residents on a mechanical soft diet.</p> <p>Interview on 06/04/24 at 12:06 P.M. with Dietary Supervisor #496 confirmed the green handled scoop of vegetables for the mechanical soft diets fell short of the four-ounce portion per the spread sheet, and the mechanical soft diets should have received the same vegetable as the regular diets. After the interview, the mechanical soft diets began to receive four ounces of Prince [NAME] vegetables.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365987	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Calcutta Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 48444 Bell School Road Calcutta, OH 43920	
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 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** 46195</p> <p>Based on observation, interview, and facility recipe, the facility failed to ensure food was served at an appetizing temperature and acceptable palatability. This had the potential to affect 89 residents who received meals in the facility. The facility identified four residents (#6, #32, #35, and #395) as receiving nothing by mouth. The facility census was 93.</p> <p>Findings include:</p> <p>Observation on 06/04/24 from 11:04 A.M. to 11:10 A.M. of Dietary [NAME] #480 taking the temperature of the food items on tray line revealed the pizza pasta casserole was 185 degrees Fahrenheit (F), Prince [NAME] Vegetables was 174 degrees F, the milk was 38 degrees F, and the lemon strawberry fluff dessert was 35 degrees F.</p> <p>Tray service for the dining rooms and hall trays began at 11:15 A.M. As the second to the last cart for 100 hall was finished being loaded, the surveyor requested at 12:20 P.M. a test tray be added at the end of the last cart for 200 hall. The test tray was plated at 12:31 P.M. and placed on the 200 hall cart. The cart was moved to the 200 hall and arrived at 12:34 P.M. After the last tray was passed to residents, the test tray was removed from the cart at 12:44 P.M. and was taken to a desk at the end of 200 hall next to exit door number four by Dietary Supervisor (DS) #496 along with Corporate Chef #477 and the surveyor.</p> <p>DS #496 checked the temperatures of the food using a facility thermometer as the surveyor tasted the food for temperature and palatability. The pizza pasta casserole was 143 degrees F, had a good flavor and tasted warm. The Prince [NAME] vegetable blend was 142 degrees F, had a good flavor, and tasted warm. The four-ounce carton of two percent milk was 63 degrees, tasted warm, and was unpalatable. The strawberry lemon fluff dessert was 61 degrees, tasted warm, and was unpalatable.</p> <p>DS #496 at 12:47 P.M. drank a sample of the milk and confirmed the milk was too warm and was not palatable. DS #496 then tasted the dessert and confirmed it was too warm since the dessert had cream cheese and whipped cream in it.</p> <p>Interview on 06/04/24 at 12:48 P.M. with Corporate Chef #477 stated at the point of service no cold item should be more than 50 degrees F and confirmed the milk at 63 was too warm and would be unpalatable and the dessert should have been below 50 degrees at the point of service.</p> <p>Review of facility recipe for lemon strawberry fluff dessert revealed the ingredients of the dessert were graham cracker crumbs, sugar, butter, gelatin, lemon juice, pureed strawberries, cream cheese and whipped topping.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46195</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure food was prepared, served, and stored under sanitary conditions. This had the potential to affect 89 residents who received food from the kitchen. The facility identified four residents (#6, #32, #35, and #395) as receiving nothing by mouth. The facility census was 93.</p> <p>Findings include:</p> <p>1. Observation during the kitchen tour on 06/03/24 from 8:10 A.M. to 8:45 A.M. with Dietary Supervisor (DS) #496 revealed the following concerns:</p> <ul style="list-style-type: none"> -The floor of the walk-in freezer had a build of dirt and debris under the shelving units and frozen peas were scattered over the floor. -In the walk-in freezer, there was one gallon size storage bag with seven biscuits dated 05/30/24 unsealed and open to air. -In the walk-in cooler, there were two five-pound containers of sour cream with a best buy date of 06/01/24. -In the dry storage area, there was one ten-pound bag of dried angel hair pasta one fourth full open to air and not dated, and there was one two-pound bag of brown sugar opened and resealed with no date of when opened. -Observation of the fan mounted on the wall in the dish machine room and blowing towards the dish machine revealed there were visible fibers of black dust blowing from the metal guard. -Observation of the two-door reach in cooler located near the steam table revealed there were two containers of two-pound cottage cheese with a best buy date of 06/01/24. There was one opened and resealed factory plastic bag with 11 hotdog's sitting in a square metal container undated. There was one gallon storage container with approximately 12 slices of deli turkey undated. There was one factory five-pound factory bag of shredded cheddar cheese opened and resealed with no date. There was one gallon storage bag of seven cooked chicken breasts undated. There was approximately three-fourths of a one-pound opened and resealed factory bag of provolone sliced cheese undated. <p>At the time of observation, DS #496 confirmed the areas of concern.</p> <p>Review of facility policy Food Receiving and Storage, revised July 2014, revealed food service personnel would maintain clean food storage areas at all times. All foods stored in the refrigerator or freezer would be covered, labeled, and dated.</p> <p>Review of facility policy Luncheon/Deli Meat Food Storage and Usage, reviewed 01/01/24, revealed any luncheon meat that was not consumed within five days of opening would be discarded no later than the sixth day. Packaging would be clearly marked with opening dated and use by date.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Observation on 06/04/24 from 8:21 A.M. to 8:29 A.M. of the running dish machine with Dietary Supervisor (DS) #458 revealed a plaque posted on the dish machine revealed a recommended sanitizing rinse temperature of 180 degrees F. Dishwashing racks full of dishes were being run through the machine, and there were two full racks of dishes sitting on the clean side of the dish machine.</p> <p>Observation of the dish machine at 8:21 A.M. with DS #458 revealed the temperature gauges on the dish machine indicated the sanitizing rinse temperature was 178 degrees F.</p> <p>Interview on 06/04/24 at 8:25 A.M. with Dietary Aide #400 stated he hadn't looked at the temperature gauges of the dish machine since he had been too busy running items through the dish machine.</p> <p>Observation of the dish machine at 8:25 A.M. with DS #458 revealed the temperature gauges on the dish machine indicated the sanitizing rinse temperature was 165 degrees F.</p> <p>Observation of the dish machine at 8:26 A.M. with DS #458 revealed the temperature gauges on the dish machine the sanitizing rinse temperature was 162 degrees F.</p> <p>Observation at 8:27 A.M. of Dietary Supervisor #458 using a TempRite dishwasher temperature test strip (another way to test the dish machine to ensure the temperature of the dish machine was reaching a sanitizing temperature) through the dish machine revealed the blue strip at the end of the test strip remained blue. Dietary Supervisor #458 confirmed at the time of observation there had been no change to the color strip at the end of the test strip.</p> <p>Review of the manufacturer's instructions printed on the bag where the TempRite dish washer temperature test strips were stored with Dietary Supervisor #458 revealed if the proper temperature for sanitation had been met, the blue strip at the end of the test strip would have changed to orange.</p> <p>Interview at 8:27 A.M. with Dietary Supervisor #458 confirmed the temperature of the rinse of the dish machine was not reaching the recommended sanitizing temperature of 180 degrees F was being met, and the TempRite dish washer temperature test strip indicated sanitation was not being met. DS #458 stated dietary staff would stop using the dish machine until it could be fixed.</p> <p>Review of the facility policy Dishwashing, Machine Use, revised March 2010, revealed dishwashing machines that use hot water to sanitize may not be less than 180 degrees and no more than 194 degrees. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures would be reported to the supervisor and corrected immediately. If hot water temperatures do not meet requirements, the use of the dish machine would cease immediately until temperatures were adjusted.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. Observation on 06/04/24 at 10:45 A.M. of Dietary Aide #458 washing the parts of the robo coupe (a type of commercial blender) in the three compartment sink revealed Dietary Aide #458 washed the blade of the unit in the first compartment with soapy water, rinsed it in the second compartment with clean water and then dipped the blade in the third compartment with the sanitizing solution and immediately lifted it out of the solution and shook the blade three times and then dipped the blade back into the sanitizing solution and immediately lifted the blade out of the solution and shook it three times and placed the blade on a drying rack. She then took the bowl of the unit and washed it in the first compartment with soapy water and rinsed it in the second compartment with clean water. Dietary Aide #458 then submerged the bowl into the sanitizing solution in the third compartment and rolled it around in the solution for approximately ten seconds and placed the bowl in the drying rack. Dietary Aide #458 then took the lid of the unit and washed it in the soapy water in the first compartment, rinsed the item in clean water in the second compartment, and then submerged the lid into the sanitizing solution in the third compartment and rolled the lid the solution for approximately 10 seconds and placed it in the drying rack.</p> <p>Observation of the chemical company's literature posted above the three-compartment sink revealed items should remain in the sanitizing solution for a minimum of 60 seconds.</p> <p>Interview on 06/04/24 at 10:46 A.M. with Dietary Aide #458 revealed when asked how long items need to stay in the sanitizing solution for the items to be considered sanitized, she replied I am not sure how long the items should stay in the sanitizer.</p> <p>Interview on 06/04/24 at 10:49 with Dietary Supervisor #496 revealed when asked how long items need to stay in the sanitizing solution for the items to be considered sanitized, she replied ten seconds. When reviewing the chemical company's literature posted above the three-compartment sink with Dietary Supervisor #496 at the time of interview, Dietary Supervisor #496 confirmed the robo coupe parts hadn't stayed in the sanitizing solution for the required minimum of 60 seconds.</p> <p>4. Observation on 06/04/24 from 11:56 A.M. to 12:33 P.M. of tray line revealed at 12:20 P.M. Dietary [NAME] #480 took his bare hand to remove from a rectangular silver storage container sitting on top of the cook top a baked potato. He then placed the potato on a plate and used his bare hand to hold the potato as he cut open the potato. At 12:24 P.M. Dietary [NAME] #480 Dietary [NAME] #480 took his bare hand to remove from a rectangular silver storage container sitting on top of the cook top a baked potato. He then placed the potato on a plate and used his bare hand to hold the potato as he cut open the potato.</p> <p>Interview on 06/04/24 at 12:32 P.M. with Dietary [NAME] #480 confirmed he had used his bare hands to cut open the baked potatoes.</p> <p>Interview on 06/04/24 at 12:34 P.M. with Corporate Chef #477 confirmed Dietary [NAME] #480 should have used a gloved hand to cut open the baked potatoes instead of using his bare hand.</p>		