STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255169	A. BUILDING _____ B. WING _____	09/21/2023

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ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 9/18/23 through 9/21/23. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F645, F656, F689, F725, F732, and F812. The facility had a census of 72 and was licensed for 100 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		10/13/23

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

Electronically Signed | 10/13/2023

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and the facility policy review the facility failed to honor a resident's right to smoke at the designated times to smoke per facility's policy for one (1) of four (4) residents that smoke. Resident #46. Finding include: Record review of the facility's "Smoking Policy," revised 10/22 revealed, "The decision with regard to smoking is a personal matter and should be treated as such ... Residents will be supervised by facility staff ..." Record review of the facility's policy, "Resident Rights" with latest revision date 11/17 revealed, "All residents in a long term care facility have rights guaranteed to them under Federal and State Law. Residents residing at this facility will be guaranteed a dignified existence, self determination, and communication with and	F 550	a. On 9/21/2023, the Director of Nurses and Administrator immediately assigned specific staff members to take residents that smoked out to designated smoking area on the assigned smoking times. On 9/22/2023, the Director of Nursing and Administrator, created a Smoker□s Box to hold resident□s cigarettes, lighters, etc. for residents smoke break to prevent delay in residents□ smoking times. On 9/21/2023, the Director of Nurses verified every resident who wanted to smoke was taken to smoke at the scheduled time. No issues were identified.	

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F 550	Continued From page 2 access to persons and services inside and outside the facility. These rights include: 1. The right to exercise his/her rights without interference, coercion, discrimination, or reprisal and shall be supported by the facility in the exercise of these rights ... 30. To be treated with dignity and respect ..." Record review of facility's "Staff Assignment for Residents Smoke Breaks," revealed the department assigned to the designated smoking times every the two (2) hours, beginning at 8:00 AM and ending at 8:00 PM. CNAs are assigned to the 8:00 AM, 4:00 PM, 6:00 PM, and 8:00 PM smoke breaks; Housekeeping is assigned to 10:00 AM, Activities is assigned to 12:00 PM, and Dietary is assigned to 4:00 PM to the smoke breaks. On weekends, Housekeeping/Restorative Aid are responsible to the 12:00 PM smoke break. On 9/19/23 at 10:20 AM, during an interview with the Resident #46, he explained he has smoked for 40 years about one (1) pack a day. On 9/19/23 at 12:10 PM, observed resident #46 sitting at the nurse's station requesting to go smoke. He reported its past time to smoke, and he is ready for a cigarette. No staff were observed responding to resident's request to be taken out to smoke. On 9/19/23 at 12:40 PM, observed resident in the hallway continuing to wait for assistance to go smoke. Resident #46 complained that although there are designated times to smoke, it is often late. On 9/20/23 at 12:10 PM, observed Resident #46	F 550	b. Residents who smoke have the potential to be affected by this alleged deficient practice. c. On 9/22/2023, the Facility Department Heads and staff were inserviced by Director of Nursing on Resident Rights and Resident Smoking Policy with Scheduled Smoking Times. d. On 9/21/2023, the Director of Nursing or Staff Development Nurse began monitoring smoking residents taken for smoke breaks posted scheduled times 5 times a week for 4 weeks and then three times a week for 4 weeks and then one time a week for 2 months. Any areas of concern will be corrected and forwarded by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review and follow up Including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted.	

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F 550	Continued From page 3 at the nurse's station telling staff he is ready for a cigarette. Once again, he explained the smoke break is late again. Observed staff around the nurse's station and no one attempting to take the resident to smoke. On 9/20/23 at 12:30 PM, an observation revealed the Staff Development /Infection Preventionist with cigarettes in her hand. She explained she was going to take the resident to smoke at this time but was unable find a lighter. On 9/20/23 at 12:40 PM, Resident #46 was observed in the hall, still waiting for someone to assist him with a smoke break. On 9/20/23 at 2:00 PM observed Resident #46 sitting by the nurse's station on the A hall, resident was requesting staff to take him to smoke. Once again, no staff were observed assisting the resident to smoke. On 9/20/23 at 03:15 PM, during an interview with the Director of Nursing (DON), she explained she expects staff to follow the designated smoking assignments and times for residents to smoke. She confirmed smoking is a resident's right and should be respected as well as all residents' rights. She explained she is aware of how important smoking is to Resident #46. On 9/20/23 at 3:30 PM, during an interview with the Administrator, he explained he was not aware the residents were not smoking at the scheduled times allowed for the residents nor was he aware some staff were not following assignments. He confirmed smoking is a resident's right and should be honored. He expects the staff to follow the smoking assignments and schedule and to try	F 550	A Quality Assurance and Improvement Committee Meeting was held on 10/13/2023. The next Quality Assurance and Improvement Committee will convene on 11/15/2023. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 550	Continued From page 4	F 550		

and keep to the scheduled time. He is aware Resident #46 is always ready to go smoke and his right should be honored and respected.

On 9/20/23 at 4:30 PM, during an interview with the Housekeeper Supervisor, she explained housekeeping has two (2) staff members that smoke and one of them usually takes the residents out to smoke at 10:00 AM. Today she reported a dietary staff worker took residents out to smoke at 10:00 AM, because her staff were busy. She reported housekeeping is often late on taking residents to smoke because she expects her staff to complete a task they are involved in, prior to taking the residents to smoke. She explained CNAs and kitchen staff also take residents out to smoke.

On 9/20/23 at 4:40 PM, during an interview with the Activity Director, she explained the facility does not always follow the smoking assignment schedule, as she may not even be in the building at the time activities are assigned on the smoking schedule. She confirmed she did not take the residents out to smoke at 12:00 on 09/19/23, because she had gone on an outing with other residents and was not in the building. The Activity Director admitted she did not arrange for anyone to take her place today, because when the CNAs go out to smoke, they often take the residents that smoke out with them.

On 9/21/23 at 2:10 PM, during an observation an interview with Certified Nurse Aide (CNA) #7, the CNA explained to Resident #46 that she will take him to smoke after she completes taking care of her residents. At this time, an interview with CNA #7 revealed residents are allowed to smoke every 2 hours. The CNA explained that although the

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F 550	Continued From page 5 staff are good at taking the residents out to smoke, it's just not always on time. On 9/21/23 at 2:15 PM, during an interview with the Dietary Manager (DM), she confirmed that for the 2:00 PM smoke break, the dietary staff are responsible for taking the residents to smoke. She explained at 2:00 PM, there are two (2) residents that smoke, and both are in wheelchairs, so two (2) kitchen staff members usually assist those residents with their smoke break. On 9/21/23 at 2:30 PM, Resident #46 was still waiting to be assisted to smoke. The DM explained there was no lighter in the box with the cigarettes, therefore in an effort to find a lighter, the smoking time was delayed. A record review of the "Face Sheet" revealed the facility admitted Resident #46 on 07/26/23, with diagnoses that included Cerebral Infarction due to Occlusion or Stenosis of Small Artery and Encephalopathy. Record review of 5-Day Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/02/23, revealed that Resident #46 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS also revealed that the resident currently used tobacco. Record review of facility's list of "Smokers" revealed Resident #46's name.	F 550		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		10/13/23

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F 645	Continued From page 6 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was	F 645		

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F 645	Continued From page 7	F 645		

transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record review and facility policy review, the facility failed to show evidence of an accurate Level I Preadmission Screening (PAS) to determine if the resident had a mental illness prior to admission to the facility for one (1) of 20 sampled residents. Resident # 56.

Findings include:

Review of the facility's policy, "Pre-Admission Screening PAS/PASRR (MS only)," with a revision

a. On 9/22/2023, the Social Services Director
immediately completed a Mississippi Pre Admission Screening and
Resident Review (MS PASRR) level II change
in status request on resident #56's and uploaded
to Medicaid Long Term Services and Support (LTSS) System.
Representative from Medicaid's LTSS

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F 645	Continued From page 8 date of 10/18, revealed, "Anyone applying for admission into a nursing facility must be approved prior to the admission by the Division of Medicaid (DOM) and/or the appropriate Level II authority. The PAS (Preadmission Screening) with Level I PASRR (Preadmission Screening and Resident Review) must be submitted to DOM and approved prior to admission to a nursing facility regardless of payment source. Level I PASRR (Pre-Admission Screening and Resident Review) 1. Anyone applying for admission into a Title XIX certified facility must have a Level I PASRR that is completed, signed and dated by a physician licensed in the State of Mississippi. 2. The Level I PASRR will be submitted electronically to DOM. 3. The Level I PASRR may be dated up to 30 days prior to the date of admission. 4. The Level I PASRR screening is included in the PAS ..." A record review of the Preadmission screening (PAS) Summary and Physician Certification, dated 3/25/22, for Resident #56, revealed the facility documented that Resident #56 did not have a major mental illness, did not have a history of mental illness and did not take psychotropic medication or have a history of taking psychotropic medication. A record review of the "Face Sheet" for Resident #56, revealed an admission date of 3/24/22 with diagnoses that included Schizophrenia, unspecified, Depression, unspecified, and Cocaine Dependence, uncomplicated. A record review of the "Physician Orders," for the month of September 2023, revealed a physician order, with an order date of 3/24/22, for "Quetiapine Fumarate (Seroquel) 100 mg (milligram) tab take 1 (one) tab PO (by mouth)	F 645	screened Resident #56 for Level II on 9/23/2023 and found him suitable for Nursing Facility placement. On 9/22/2023, Director of Nurses verified resident's PASSR was updated and uploaded to LTSS. No issues were identified. b. All New Resident Admissions have the potential to be affected by this alleged deficient practice. c. On 9/19/2023 Director of Nurses reviewed pre-admission screenings to ensure accurate screening of mental illness prior to admission and no issues were identified. On 9/22/2023, the Social Services director was inserviced by Director of Nursing on Pre admission screening/PASRR policy. d. On 9/19/2023, Director of Nursing began monitoring all PASRR on new resident admissions prior to submission for accuracy and will continue to monitor weekly for 4 weeks and then 2 times a month for 2 months. Any areas of concern will be corrected and forwarded by the Director of Nurses to the quarterly Quality	

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F 645	Continued From page 9 QHS (every hours of sleep) for Schizophrenia." A record review of the "Care Plan" for Resident #52, revealed a problem with an onset date of 3/25/22 for "Resident has potential for injury R/T (related to) Antipsychotic medications", "Potential for altered mood state related to DX (diagnosis) of Schizophrenia" problem onset date 3/25/22 and an additional problem identified on 3/25/22 as "Potential for altered mood state related to Dx (diagnosis) of Depression." A record review of the "Care Plan" for Resident #52, revealed a problem with an onset date of 3/25/22 for "Resident has potential for injury R/T (related to) Antipsychotic medications" and an additional problem identified on 3/25/22 as "Potential for altered mood state related to Dx (diagnosis) of Depression." A record review of the EMAR (electronic medication administration record) revealed Resident #52 is receiving Quetiapine Fumarate (Seroquel)100 mg every night for schizophrenia, with an order date of 3/24/22 and a start date of 3/31/22. Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/4/23, revealed a Brief Interview for Mental Status (BIMS) score of seven (8) which indicated the resident had severe cognitive impairment. Additionally the MDS revealed an active diagnosis of Schizophrenia and listed Psychosis as a behavior. On 9/20/23 at 12:12 PM, in an interview with Director of Nursing (DON), she confirmed, the Pre-Admission Screening (PAS) was not	F 645	Assessment and Improvement Committee for review and follow up Including any needed corrective actions or changes to Current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee Meeting was held on 10/13/2023. The next Quality Assessment and Improvement Committee will convene on 11/15/2023. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 645	Continued From page 10 documented correctly. She stated the Social Worker (SW) is responsible for completing the PAS. She revealed it should have been done before admission, to make sure that the facility can meet the needs of the resident. On 9/20/22 at 2:10 PM, in an interview with the SW, she revealed she is responsible for making sure the PAS is completed. She stated she has not been trained properly but it is her responsibility to make sure it is accurate. The SW said she mentioned to the Administrator that she did not feel comfortable looking at diagnosis or medications, because she's not a nurse and doesn't know what the medications are used for. The SW stated she did not know the resident had a diagnosis of Schizophrenia and was taking Quetiapine (Seroquel) upon admission. On 9/20/22 at 3:01 PM, in an interview with the Administrator, he confirmed it is the responsibility of the SW to complete the PAS. He stated that it is a team effort, but nobody does a final check to make sure everything is completed. He stated the PAS is done to make sure that the facility can meet a resident's needs.	F 645		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		10/13/23

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F 656	Continued From page 11	F 656		

assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on interviews, record reviews and facility policy reviews, the facility failed to ensure that the

a. On 9/18/2023, the Certified Nursing Assistant #1

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F 656	Continued From page 12 comprehensive care plan was implemented by leaving a dependent resident unsupervised while performing Activities of Daily Living (ADL) for one (1) of 20 sampled residents. Resident #52 Findings include: Review of the facility's, "Care Plan Policy," revised 8/17, revealed ... "The care plan must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practical physical mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged, and must be consistent with resident's written plan of care. The facility shall use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility staff shall follow the care plan ..." Record review of the facility's "Care Plan" for Resident #52 revealed the resident had a Problem/Need identified on 3/2/22, as "Resident has a DX (diagnosis) of Hemiplegia/Hemiparesis," with the goal that the resident will have no complications related to the diagnosis through the next review date of 11/10/23. One of the approaches to meet this goal was to assist the resident with ADLs as needed. During an observation on 9/18/23 at 8:45 AM, Resident #52 was observed dry shaving himself in his room without supervision. The resident was observed with bright red blood running down his face. The resident said he was told by Certified Nursing Assistant (CNA) #1 to shave himself,	F 656	was Immediately educated by Director of Nursing on following Resident #52□s Care plans to assist with Activities of Daily Living (ADL). On 9/18/2023, Director of Nurses verified residents with orders for coagulants were assisted with shaving. No issues were identified. b. All residents that need assistance with ADL□s have the potential to be affected by this alleged deficient practice. c. On 9/18/2023, the Certified Nursing Assistant #1 was educated by Director of Nursing on following Resident #52's Care plans to assist with Activities Daily Living. On 9/19/2023, facility DON began inservicing C.N.A□s following Resident Care Plans and was completed on 9/26/2023. d. On 9/19/2023, the Director of Nursing began reviewing care plans and monitoring Resident ADL Care with focus on shaving facial hair on 5 residents 5 times a week for 4 weeks, and then 3 times a week for 4 weeks, then monthly for 2 months. Any areas of concern will be corrected	

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F 656	Continued From page 13 because he was busy with another resident. During an interview on 9/18/23 at 9:06 AM, CNA #1 confirmed he failed to follow the care plan because the care plan states to assist with ADL's. The CNA revealed he was aware that Resident #52 could only use his right hand. The CNA added that the resident had an electric razor, but it didn't work anymore. The CNA explained he thought Resident #52 could shave himself without hurting himself and didn't think the resident would try to dry shave himself. During an interview on 9/18/23 at 10:00 AM, with the Director of Nursing (DON), she confirmed that CNA #1 failed to follow the care plan for Resident #52 by not assisting the resident with shaving, as with the use of only one hand, the resident needed help. During an interview on 9/19/23 at 9:30 AM, with Licensed Practical Nurse (LPN) #2, and Registered Nurse (RN) #1, they both confirmed CNA #1 failed to follow the care plan. Both nurses said the CNA should have stayed in the room with the resident to assist him because with only the use of one hand, the resident could not hold the mirror and shave at the same time. Both nurses said they expect the staff to follow the plan of care. During an interview on 09/21/23 at 11:56 AM, the Administrator revealed he did not know the resident's electric razor was not working. The Administrator said he would have provided another electric razor. The Administrator confirmed Resident #52 should not be left unsupervised with a razor to shave himself.	F 656	and forwarded by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee Meeting Was held on 10/13/2023. The next Quality Assurance and Improvement Committee will be held on 11/15/2023. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 656	Continued From page 14 Record review of the "Face Sheet" for Resident #52 revealed the facility admitted the resident to the facility on 3/2/22, with diagnoses that included Hemiplegia following Cerebral Infraction affecting the left non-dominant side, Coronary Artery Disease, Muscle Weakness and Cognitive Communication Deficit. Record review of the quarterly Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 08/10/23, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to supervise and protect a dependent resident to prevent injury for one (1) of five (5) residents reviewed for accidents. Resident #52 Finding include: Review of the facility policy, titled "Accident Prevention" revealed, "Each resident shall receive adequate supervision and assistive devices to	F 689	a. On 9/18/2023, the Certified Nursing Assistant #1 assisted Resident #52 in completing his shaving of facial hair task. Registered Nurse (RN) Supervisor assessed Resident #52□s superficial cutaneous nicks with no treatment required. No active bleeding or injury noted. On 9/18/2023, Director of	10/13/23

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F 689	Continued From page 15 prevent accidents. The environment will be free from accidental hazards for all residents, staff, and visitors through: ..." Record review of the facility's policy, "Resident Rights" with latest revision date 11/17 revealed, "All residents in a long term care facility have rights guaranteed to them under Federal and State Law. Residents residing at this facility will be guaranteed a dignified existence, self determination, and communication with and access to persons and services inside and outside the facility. These rights include:... 37. To a safe...environment." On 9/18/23 at 08:45 AM, an observation revealed Resident #52 sitting in bed with the head of the bed elevated and dry shaving himself. There was no shaving cream or soap on the resident's face. The resident had several cuts on his face with blood running down his face. The resident said he was told to shave himself because the Certified Nursing Assistant (CNA) did not have time. The resident said he told the CNA to give him the razor, and he would shave himself. Resident #52 revealed he's having problems shaving himself because he only has use of one hand, as he is paralyzed on his left side. The resident also said he cannot hold the mirror and shave himself. There were three cuts on his face and one on his neck. In an interview on 9/18/23 at 9:06 AM, with CNA #1, he stated the resident told him he wanted to shave himself, so he gave the resident the razor. CNA #1 confirmed he left the resident unsupervised while he provided care for another resident. CNA #1 commented that Resident #52 always bleeds when he is shaved. He stated that	F 689	Nurses verified residents with orders for coagulants were assisted with shaving. No issues were identified. b. All dependent residents who need assistance with having have the potential to be affected by this alleged deficient practice. c. On 9/18/2023, the Certified Nursing Assistant #1 was inserviced by Director of Nursing on providing supervision and/or assistance to dependent residents to promote resident safety. On 9/19/2023, facility DON began inservicing C.N.A□s on Accident Prevention Policy and A.M. Care Policy and was completed on 9/26/2023. d. On 9/19/2023, the Director of Nursing began monitoring Resident ADL Care with focus on shaving facial hair on 5 residents 5 times a week for 4 weeks, and then 3 times a week for 4 weeks, then monthly for 2 months. Any areas of concern will be corrected and forwarded by the Director of Nurses to the quarterly Quality	

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F 689	Continued From page 16 Resident #52 even bleeds when he shaves him, because the resident takes a blood thinner. CNA #1 said the resident did have an electric razor, but it was no longer available, as it broke. During an interview with the Director of Nursing (DON), on 9/18/23 at 10:00 AM, she confirmed CNA #1 failed to supervise the resident while the resident was shaving himself. The DON confirmed Resident #52 should not have been shaving himself unsupervised, as the resident had not been assessed to make sure that he's safe to shave himself without assistance. After acknowledging that the resident cut himself in four (4) different places, the DON confirmed the resident is not safe to shave himself without assistance. On 9/19/23 at 9:07 AM, during an interview with Licensed Practical (LPN) #1, she said the staff is trained to always supervise the residents while shaving. The resident is only able to shave themselves when they have been assessed and educated with demonstration that they can safely shave without supervision. Review of the Certified Nursing Assistant (CNA) #1's, "CNA Performance and Skills Evaluation," dated 8/31/22, revealed he was in-serviced on accidents/incidents and shaving residents. During an interview on 9/19/23 at 10:30 AM, the Nurse Practitioner (NP) confirmed the resident is taking both Aspirin and Plavix because he has had a Cerebral Vascular Accident (stroke) and the medication prevents the blood from clotting. The NP confirmed the resident is dependent on staff to assist with Activities of Daily Living (ADL's) because he only has the use of one hand and	F 689	Assessment and Improvement Committee for review and follow up Including any needed corrective actions or changes to Current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee Meeting was held on 10/13/2023. The next Quality Assurance and Improvement Committee will convene on 11/15/2023 By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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F 689	Continued From page 17 cannot provide care without assistance. The NP said the resident should not shave himself without supervision. On 9/21/23 at 11:56 AM, during an interview the Administrator, revealed he did not know the resident's electric razor was not working. The Administrator said he would have provided another electric razor. The Administrator confirmed Resident #52 should not be left unsupervised with a razor to shave himself. Record review of the "Face Sheet" for Resident #52 revealed the resident was admitted by the facility on 3/02/22, with diagnoses that included Hemiplegia following Cerebral Infraction Affecting Left Non-Dominant Side, Coronary Artery Disease (CAD), Muscle Weakness and Cognitive communication. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/10/23 revealed Resident #52 had a Brief interview for Mental Status (BIMS) of 14, which indicated Resident #52 was cognitively intact.	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		10/13/23

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F 725	Continued From page 18 accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review, interview, Payroll Based Journal review and facility policy review, the facility failed to ensure sufficient nursing staff were available to provide nursing services for the resident's highest practicable well-being for the third quarter of 2023 for eight (8) of 26 weekend days and for three (3) days in the past two (2) weeks. This has the potential to affect all 72 residents in the facility. Findings include: A record review of the facility's policy "Nursing Services-Staffing" with latest revision date 11/17 revealed "1. Staffing- The facility will have sufficient nursing staff twenty-four hours every day to provide nursing and nursing related services to attain or help maintain the highest practicable physical, mental, and psychosocial well-being of each resident as is determined in	F 725	a. On 9/22/2023, the Staff Development Nurse was immediately inserviced by Director of Nursing on Sufficient Staffing for the daily care of residents and current staffing levels to meet resident needs. On 9/21/2023, the Director of Nurses verified sufficient staff for resident care was on-site. No issues were identified. b. All residents have the potential to be affected by this alleged deficient practice. c. On 9/22/2023, the Staff Development Nurse and Director of Nursing reviewed the	

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the comprehensive assessment and the resident care plan. 2. The facility will comply with established staffing requirements by the individual state governing agencies ..."

On 09/18/23 at 09:06 AM, during an interview with Certified Nurse Aide (CNA) #1, he explained Resident #52 asked him for a razor this morning and he gave the resident the razor, because he didn't have time to shave the resident. The CNA confirmed he left the resident unsupervised while he provided care for another resident, and Resident #52 ended up cutting himself with the razor.

On 09/18/23 at 11:50 AM, during an interview and observation with Resident #66 in his room, he reported the turnover of CNAs at the facility is bad, and the CNAs are always working short and cannot wait on the residents properly to provide all the care that's needed. He explained CNAs are short and quick and don't always have time to do everything they need for him and other residents and this has happened on all shifts. He tries to do everything for himself, so he does not have to ask for help much.

On 09/18/23 at 11:55 AM, during an interview with CNA #3, she explained she was called in this morning and arrived around 09:30 AM. She revealed she gets called in several times a week. The CNA reported that her resident assignment averages 10 or more residents, but it depends on the number of CNAs working the shift. The CNA reported she does not always have time to complete all her duties, it just depends on if the staff is short for the shift.

On 09/18/23 at 02:15 PM, during an interview

Employee Daily
Time from Kronos Time System for the past
fourteen (14) days to ensure Sufficient Staffing
for the daily care of residents. On 9/22/2023,
the Staff Development Nurse was inserviced by
Director of Nursing on Sufficient Staffing for
the daily care of residents. On 9/26/2023, the
Quality Assurance Committee reviewed the policy,
Nursing Staffing with no recommended changes to
the policy.

d. On 9/21/2023, The Director of Nursing or RN
Supervisor reviewed Daily Staffing Assignment
Sheets and verify Time Sheets daily for 30 days,
and then 5 times a week thereafter. Any areas of
concern will be corrected and forwarded by the
Director of Nurses to the quarterly Quality
Assessment and Improvement Committee for review
and follow up Including any needed corrective
actions or changes to Current plan at least
quarterly. Additional training and/or
disciplinary action will be considered as

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F 725	Continued From page 20 with CNA #1, he explained the staffing has been short on CNAs for a long time. On 09/18/23 at 03:21 PM, during an interview with Resident #51, he explained the CNAs have been working short for some time. It will get better and then bad again. He explained he is always staying wet from urinating, and it drenches his pants and runs into his right shoe. Some CNAs are good, but others are not, and this is on all shifts. The resident stated he tries to do for himself, so he doesn't have to ask for help. He explained the shortage is especially bad on the weekends. On 09/19/23 at 08:30 AM, during an interview with CNA #4, she explained that one of the Licensed Practical Nurses (LPNs) had a crisis at home and had to leave, so the Registered Nurse (RN) supervisor is on the medication cart now. She reported staff have been working short for a long time, but the new Director of Nurses (DON) has cracked down on the call-ins. The call-ins were bad, especially the weekends, and the staff would work short. She explained this has happened on all shifts. On 09/19/23 at 10:10 AM, during an interview with CNA #5, she explained the number of residents each shift depends on the number of CNAs working. The number of CNAs needed on day shift to make sure all duties are completed is eight (8) CNAs, but day shift usually works with six (6) aides. The facility usually works short one (1) or two (2) times a week. The CNA revealed that on some days she can complete all her duties and on other days, she cannot. The CNA stated that at one time, the facility used agency staff, but they are no longer using agency staff to	F 725	warranted. A Quality Assessment and Assurance Committee Meeting was held on 10/13/2023. The next Quality Assurance and Improvement Committee will be held 11/15/2023. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	

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help with the lack of staff.

On 09/19/23 at 10:20 AM, during an interview with CNA #6, she explained she usually has 10 residents on her shift, depending on if CNAs call in. She revealed when they work short, they will have up to 14 to 15 residents with an average of 3-4 showers, depending on if any extra showers were carried over from the day before due to showers from the day before having to be postponed due to working short. The CNA explained she tries to complete all her assigned duties, but somedays it's impossible. She explained the CNA shortage averages maybe 1-2 times a week. The day shift works good with eight (8) CNAs on the day shift but will work with five (5) or six (6) on most days.

On 09/20/23 at 11:50 AM, during an interview with RN #4, she explained she works as needed for the facility and sometimes she works several times a week and works 16 hours on the weekend as supervisor. Staffing on the weekend can be challenging due to call-ins. She has had to work the medication cart sometimes on the weekends leaving no RN supervisor for the evening shift. Some CNAs will come in early, and others will work over a couple hours to help the other shift.

On 09/20/23 at 02:45 PM, during an interview with CNA #2, she explained CNA staffing has been short for a while. She averages 10-13 residents most days and some days does not get everything done.

On 09/20/23 at 02:55 PM, during an interview with CNA #4, she explained the facility has no agency working in the building but does work

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short 1-2 times a week. Day shift usually works well with eight (8) CNAs but most of the time they have 5 or 6 and it is hard to get all the work done on those days.

On 09/20/23 at 03:45 PM, during an interview with the Administrator, he explained the time clock goes directly to PBJ (Payroll-Based Journal Reporting) for the facility after he approves it. He explained sometimes a fingerprint on the time clock may not have carried over or sometimes the CNA students or nurses in training may not have carried over. He reported he thinks some days may have been entered in error and was not aware of low weekend staffing being triggered.

On 09/21/23 at 09:10 AM, during an interview with Licensed Practical Nurse (LPN) #2, she explained she works 11-7 shift on the A, B, and left side of the C hall. She stated she usually works with three (3) to four (4) CNAs on the 11-7 shift, but at times, there have been only two (2) CNAs. She revealed she has many times had to help with providing care and has had to stay over on the day shift to finish up the charting that she didn't have time to do.

On 09/21/23 at 10:50 AM, during an interview with the DON, she explained she does not know the full depth of staffing and what all is currently needed to fulfill the staffing requirement, but she does understand if the PBJ triggered short, it is what it is. She expects adequate staff to meet all residents' needs.

On 09/21/23 at 11:00 AM, during an interview with LPN#1, she explained she has been at the facility for over one year and the facility has not used Agency for staffing during that time. Staffing has

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been a challenge but mostly due to the call ins. The facility currently needs CNAs for all shifts. Four (4) CNAs are needed for 7-3 and 3-11 shift and three (3) CNAs are needed for 11-7 shift. LPN #1 revealed the facility does do CNA classes that she teaches and will be offering one soon.

On 09/21/23 at 09:30 AM, during an interview with RN #3, she explained she works 11-7 shift and some shifts there are plenty of CNAs and others not so much. RN #3 reported they would like to work with five (5) or six (6) CNAs but have been short with only 3 CNAs on night shift and has had to help with care at times resulting in staying over several hours to complete her charting duties.

On 09/21/23 at 12:30 PM, during an interview with the Administrator, he explained on 04/01/23 the hours for CNAs were incorrect on the PBJ report that was submitted. He explained there may have been other days in error also. He explained that since the COVID-19 pandemic staffing has been an issue. Currently the facility is using student CNAs to get more CNAs in the facility, offering advertisements for nurses and offering all shift incentives for extra shift work. The company has agreed to increase the sign-on bonus, hourly pay, and double the incentive pay. He expects staffing to be sufficient to care for all the residents and their needs.

Record review of Resident #51's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #51 was cognitively intact. Resident required limited assist for dressing self-performance of one person assist.

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Mobility devices: wheelchair (manual or electric) was checked.

Record review of Resident #66's quarterly MDS with an ARD of 08/14/23 revealed a BIMS score of 14, which indicated Resident #66 was cognitively intact. Resident required extensive assistance for toilet use of one person and one person assistance for bathing.

Record review of the facility's "PBJ Staffing Data Report CASPER Report" 1705D FY Quarter 3 2023 (April 1 - June 30) revealed " ... Excessively Low Weekend Staffing Triggered = Submitted Weekend Staffing data is excessively low ..."

Record review of the facility's "Staffing Grid" for the Third Quarter 2023 and "Period Total Reports" revealed low staffing for eight (8) of 26 days on the weekend with low staffing.

Record review of the facility's "Staffing Grid" for 9/5/23 through 9/18/23 and "Period Total Reports" revealed three (3) out of 14 days with low staffing.

Record review of the facility's "Facility Assessment" completed on 10/31/22 revealed "... Facility resources needed to provide competent support and care for our resident population during normal business operations and during emergencies: ... Staffing plan: ... As a facility we provide staff to adequately meet the acuity and needs of daily care for our resident population. Our daily census determines our budget for allotted staff and PPD is calculated daily to ensure compliance with staffing PPD... number of staff needed daily as an average: ... Nurse aides 24..."

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F 732	Continued From page 25	F 732		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	F 732		10/13/23

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F 732	Continued From page 26 is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to ensure staffing information was posted in a prominent place readily accessible to resident and visitors for four (4) of four (4) survey days. Findings include: Review of the facility's policy, "Posting of Staff," with a revision date of 10/22, revealed, "As required by Federal mandate, on a daily basis, the facility must post the following data: 1. Facility Name 2. Current Date 3. Resident Census 4. Facility-specific shifts for the 24 hour period 5. Categories of nursing staff employed or contracted by the facility, per shift 6. Actual time worked for the specified categories of nursing staff 7. Number of nursing staff working per shift ... Facility will display nurse staffing data in a clear and readable format and must be posted at the beginning of each shift, in a prominent place readily accessible to residents and visitors ..." On 09/18/23 at 11:00 AM, an observation revealed there was no posting of staffing noted throughout the building. On 09/19/23 at 3:35 PM, and observation revealed no posting of staffing noted throughout the building. 09/20/23 at 4:40 PM, an observation revealed there continued to be no posting of staffing noted throughout the building. On 09/21/23 at 9:00 AM, once again observations	F 732	a. On 9/21/2023, The Daily Staff Reporting Form (AD-093) was immediately posted in a prominent place readily accessible to residents and visitors. On 9/21/2023, the Director of Nurses verified Nursing Staffing Form was posted. No issues were identified. b. All residents have the potential to be affected by this alleged deficient practice. On 9/21/2023, the Director of Nurses verified Nursing Staffing Form was posted. No issues were identified. c. On 9/22/2023, the Staff Development Nurse was inserviced by Director of Nursing on Posting Nursing Staffing. A plastic Placeholder was installed on wall beside Nurses' Station to display the Daily Nursing Staffing for residents and visitors to observe. d. On 9/21/2023, The Director of Nursing began monitoring morning posting of Nursing Staffing Form daily for 30 days, and then 5 times	

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F 732	Continued From page 27 revealed there was no posting of staffing noted throughout the building. On 09/21/23 at 10:50 AM, during an interview with the Director of Nurses (DON), she explained she knows the staffing is required to be posted daily in a visible place where all residents, staff, and visitors can see. She explained the Staff Development nurse is responsible for posting staffing during the week. She is not exactly sure where the staffing is posted in the building, as this is her second week at the facility. On 09/21/23 at 11:00 AM, during an interview with the Staff Development Nurse, she revealed she is aware that daily posting of staffing is required and explained that she posts daily staffing by the time clock, however, she has not posted it this week. The Staff Development Nurse stated that for the weekends, she attaches the staffing to the assignment sheet and the nurses, or the supervisor are responsible for posting the staffing. On 09/21/23 11:35 AM, during an interview with the Administrator, he explained he expects staffing to be posted daily for all staff, visitors, and residents to see.	F 732	a week thereafter. Any areas of concern will be corrected and forwarded by the Director of Nurses to the quarterly Quality Assessment and Improvement Committee for review and follow up including any needed corrective actions or changes to Current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee Meeting was held on 10/13/2023. The next Quality Assurance and Improvement Committee will be on 11/15/2023. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		10/13/23

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F 812	Continued From page 28 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to discard 30 cartons of chocolate milk that expired on 9/11/23 for one (1) of four (4) days of observations of the kitchen. Findings include Review of the facility policy "Food Storage Labeling" with a received date of 05/18, revealed, "POLICY: The facility will ensure the safety and quality of food by following good storage...procedures...Identify the food item's use by date or expiration date... b. Foods stored in storage units will be survey routinely to identify and discard foods that have passed its manufacturer use-by date or expiration date...Refrigerator Storage--Weekly..." Observation on 9/18/23 at 8:31 AM, during an initial tour of the kitchen with the dietary manager, observed 30 cartons of chocolate milk in the refrigerator with an expiration date of 9/11/23. The milk was sitting in a black milk crate on top of the white milk in the refrigerator. The Dietary	F 812	a. On 9/18/2023, all of the expired milk was immediately removed from the Milk Cooler and was discarded to prevent it from being served. Proper food temperature check procedures were followed. On 9/19/2023, the milk vendor delivered milk that was not out of date (expired). The milk inventory was checked in by the Dietary Manager on 9/19/2023 and it was all in within the required freshness date. On 9/21/2023, the Administrator verified that all milk in milk cooler was not close to expiration date. No issues were identified. b. All residents served milk from the kitchen have the potential to be affected by this alleged	

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F 812	Continued From page 29 Manager said the staff use the milk in this refrigerator for the residents. During an interview on 9/21/23 at 8:50 AM, the Dietary Manager (DM) confirmed 30 cartons of chocolate milk in the refrigerator had expired on 9/11/23. The DM stated the milk must have come in Friday afternoon because she did not see them Friday morning. She further explained the cook that worked Friday afternoon was responsible for checking the dates when the milk was delivered. The DM revealed no resident had received the expired milk on the morning of 9/18/23, as she had been informed by the Dietary Aide that she had noted the expiration dates on the milk and although she did not remove the milk or inform the DM of the expired milk, no residents had received the milk that morning. However, the DM admitted that she didn't know if any of the resident's received the expired chocolate milk over the weekend. On 9/21/23 at 9:38 AM, during an interview with the Dietary Aide, she revealed she did not know the chocolate milk was expired. The Aide commented that should she have known, she would have notified the DM and removed it out of the refrigerator. On 9/21/23 at 12:26 PM, during an interview with the night cook, he revealed sometimes, the milk is delivered in the evening. The cook said the milkman takes the expired milk and leaves fresh milk. The cook added that he checks the expiration dates on the milk prior to giving it to the residents. The cook said he did not know the chocolate milk was expired, but somebody should have recognized that the milk was expired prior to today.	F 812	deficient practice. No issues were identified. c. On 9/18/2023, the Dietary manager began inservicing Dietary staff on Proper Food Procurement and checking dates on milk deliveries prior to using it. Dietary Staff Inservices completed on 9/21/2023. All milk will be checked in by the Dietary Manager for a date which is current and available for use. d. On 9/22/2023, The Facility Dietary Manager and Administrator began monitoring expiration dates on milk daily for 30 days, then weekly for 4 weeks and then monthly for 2 months. Any areas of concern will be corrected and forwarded by the Dietary Manager and Administrator to the quarterly Quality Assessment and Improvement Committee for review and follow up Including any needed corrective actions or changes to Current plan at least quarterly. Additional training and/or disciplinary action will be considered as warranted. A Quality Assessment and Assurance Committee Meeting was held on 10/13/2023. A	

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F 812	Continued From page 30 On 9/21/23 at 12:46 PM, during an interview with the milkman, he confirmed he normally delivers milk to this facility. The milkman said he takes the expired milk out of the refrigerator and discards it and replaces it with fresh milk. The milkman said he doesn't know how the milk was missed. He admitted he might have missed it. However, he has not had a problem with expired milk being left in a facility in the nine (9) years he's work for the company. During an interview on 9/21/23 at 12:49 PM, with the Director of Nurses (DON), she revealed the residents have not had any stomach issues. The DON said she didn't know if any of the residents had received any of the chocolate milk over the weekend, but she confirmed drinking expired milk can cause stomach problems with the residents. During an interview on 9/21/23 at 12:51 PM, the Administrator confirmed the milk should have been pulled out of the refrigerator and discarded. The Administrator said the Dietary Manager is responsible for checking the expiration dates and making sure the residents don't receive expired milk.	F 812	Quality Assessment and Assurance Committee Meeting was held on 10/13/2023. The next Quality Assurance and Improvement Committee will be on 11/15/2023. By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings for allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit the responses pursuant to our regulatory obligations.	