STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255262	A. BUILDING _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD COMMUNITY LIVING CENTER	1036 WEST DRIVE LAUREL, MS 39440

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/16/2023 through 10/19/2023. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F558, F561, F567, F585, F625,F677, and F812. The facility had a census of 47 and was licensed for 60 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a call light was within reach for one (1) of 15 sampled residents. Resident #26 Findings include: A review of the facility's policy, "Call Light, Use of", revised 11/15/2019, revealed " ... It is the policy of this facility to have an adequately equipped communication system that allows residents to call for staff ... Be sure all call lights are placed within reach ... The facility will routinely inspect: Call lights are placed appropriately and within reach at bedside ..."	F 558	* Rounds were made 10/19/23 by Director of Nursing and Administrator to assure call lights were in reach. Resident #26 had call light placed in reach. Resident was assessed 10/19/23 by Director of Nursing with no adverse findings. * All residents have the potential to be affected. * In-service education on call lights was given on 10/11/23 - 11/15/23 to all staff, by Director of Nursing. * Call Lights will continue being checked by Director of Nursing or Administrator beginning 10/23/23 three times a week for two weeks, then two times a week for four	11/22/23

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

Electronically Signed | 11/10/2023

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F 558	Continued From page 1 On 10/16/23 at 11:46 AM, during an initial interview and observation with Resident #26, she explained that her call light had not been in reach "many times" and that occurred on all shifts. An observation revealed the call light was on the nightstand and out of reach of the resident. She stated that she has been told by staff not to yell out, but if there was an emergency, she would yell anyway. On 10/16/23 at 12:20 PM, during an observation, Certified Nurse Aide (CNA) #1 took a meal tray into Resident #26's room and placed the tray on the bedside table. CNA #1 did not place the call light within reach of the resident. At 12:45 PM on 10/16/23, during an observation, CNA #2 entered Resident #26's room and removed the meal tray. CNA #2 did not place the call light within the resident's reach. At 1:00 PM on 10/16/23, during an interview and observation with Resident #26, she confirmed that neither CNA #1 or CNA #2 placed her call light within her reach when her tray was delivered or removed from her room. At 1:10 PM on 10/16/23, during an observation and interview with CNA #2, she confirmed that the call light was not within reach for Resident #26. She explained that the call light should always be within reach and that the residents are observed every two hours during rounds. She said it was her responsibility to make sure the call light was within reach of the resident. At 11:40 AM on 10/19/23, during an interview with Director of Nursing (DON), she explained she expected all staff to respect resident's wishes and	F 558	weeks then once monthly for three months. Any deficient practice will be brought to facilities Quality Assessment Performance Improvement committee on 11/16/23 for corrective action times 3 months.	

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F 558	Continued From page 2 keep all call lights within reach at all times. Record review of the "Admission Record" revealed the facility admitted Resident #26 on 7/03/23 with a diagnosis of Chronic Kidney Disease. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/23 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. Section G revealed she required extensive assistance with bed mobility and transfers.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		11/22/23

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F 561	Continued From page 3 facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to notify the Resident's Representative (RR) of a room change for one (1) of 15 sampled residents. Resident #39 Findings include: A review of the facility's policy, "Room Changes Policy", revised April 9, 2021, revealed, "The facility will promote resident's right to make choices and to receive written notice of a room change when being relocated ...When a resident is changing rooms at the request of facility staff, the resident and/or resident representative should receive written notification that contains the reason for the room change, the effective date of the change, and the location to which the resident will be moved ..." On 10/17/23 at 10:06 AM, a phone interview with Resident #39's RR revealed the resident was changed to a new room during his stay. The RR stated she did not know of Resident # 39's room change until she came to the facility, and the resident was not in his room. The RR reported being scared and had to look for a staff member to help her find the resident. A record review of the resident's medical record	F 561	*Resident #39 was assessed 11/02/23 by Director of Nursing with no adverse findings. *All Residents have the potential to be affected. *In-service education was reviewed with Social Worker on 11/02/23 by Administrator regarding room change notification. *Room changes will be documented in the chart beginning 11/02/23. Both verbal and written notification will be discussed with Resident and Residents Representative by Social Services prior to room change. * All room changes will be reviewed each day beginning 11/02/23 by Social Services in facilities Daily Stand up meeting. Room change forms will be kept for review by Social Services each week for four weeks then brought to monthly Quality Assurance Performance Improvement Committee on 11/16/23 for three months. Any deficient practice will be reviewed and corrective action plan put in place.	

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F 561	Continued From page 4	F 561		

revealed there was no notation of a room change for Resident #39 from December 31, 2022, to January 1, 2023.

A record review of the facility's "Census Reports" for December 31, 2022, to January 01, 2023, revealed the resident was moved from room 10A to room 19A.

A record review of the "Admission Record" revealed the facility initially admitted Resident #39 on 12/15/22 with diagnoses that included Type II Diabetes Mellitus and Dementia.

A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 6/23/23, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated he had severe cognitive impairment.

On 10/17/23 at 02:51 PM, an interview with the Social Services Director (SSD) revealed Resident #39 was admitted to the facility on 12/15/22. The SSD stated the Resident was moved from room 10A to room 19A on 1/1/23. The SSD confirmed there was no documentation that supported the facilities' effort to contact the RR regarding the room change.

On 10/19/23 at 07:37 AM, in an interview with the Administrator, she acknowledged the facility failed to notify the Resident or RR of the room change.

On 10/19/23 at 11:50 AM, in an interview with the Director of Nursing (DON), she confirmed there were no progress notes which documented the resident's room change from 10A to room 19A on

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F 561	Continued From page 5 1/1/23.	F 561		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a	F 567		11/22/23

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F 567	Continued From page 6 separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review the facility failed to ensure the residents were able to obtain funds from their trust accounts on weekends for nine (9) of (12) Resident council members interviewed. (Residents #4, #11, #17, #18, #20, #27, #28, #30 and #31) Findings Include: Review of the facility's policy titled, "Resident Trust Fund Policy & Agreement," dated 10/7/07, revealed, ..."WHEREAS the resident acknowledges that he/she has been informed and understands that he/she has the right to manage his/her own financial affairs... The Facility will give the Resident due receipt for such monetary sums..." During an interview on 10/16/23 at 3:30 PM, with the Resident Council members, Residents #4, 11, #17, #18, #20, #27, #28, #30 and #31 complained that they were not able to get their money from their trust fund on weekends. The residents said if they want money for the weekend, they must get it on Friday. The residents revealed that has been a problem for them, because if they wanted to order a pizza or food from Door Dash on weekends, they've unable to do so, as they do not have access to their money. Review of the facility's, "Resident Fund Management Service" undated, revealed	F 567	* $50.00 was placed in Medication Room 11/04/23 by Business office Manager for Residents to have access to funds on weekends. Administrator informed resident's #4,#11,#17,#18,#20,#27, #28,#30 and #31 on 11/03/23 what funds they each have and that they can request money on weekends with nurse at nurses station. Sign was posted at Business Office and at Nurses Station 11/03/23 regarding Weekend availability of Trust Fund Money for any other residents with Trust Funds. *All residents with Trust Funds have the potential to be affected. *In-service education was discussed with Business Office Manager 11/02/23 by Administrator regarding Residents accessing their personal funds on weekends. In-service education was given 11/3/23 by Business Office Manager to nurses on responsibility of getting personal funds on weekends. * Money will be checked each Monday beginning 11/06/23 by Business Office Manager and slips posted in Residents account. President of Resident Council will go over weekend money availability on 11/28/23 at Resident council. Withdrawal slips will be reviewed weekly times 4 weeks by Administrator beginning 11/4/23 then Monthly times 3 months. Funds will be increased as needed to	

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F 567	Continued From page 7 Residents #4, #11, #17, #18, #20, #27, #28, # 30 and #31 have money in the Facility Trust Fund. During an interview on 10/18/23 at 2:47 PM, with the Activity Director revealed she did not know the residents were unable to get their money on weekends. In an interview on 10/18/23 at 2:50 PM, the Business Office Manager (BOM) revealed she works Monday through Friday. She stated she leaves $50.00 with the Director of Nursing (DON) in an envelope on Fridays to be put on the medication cart, so the charge nurse can have money to give to residents that request it over the weekend. During an interview on 10/18/23 at 3:10 PM, with Registered Nurse (RN) #1, she revealed she works every other weekend. RN #1 said if the resident wants a snack, she purchases it out of the vending machine with her money. The RN stated the facility does not leave money on weekends for the residents. RN #1 confirmed that residents must request money from their account by Friday evening, or they won't be able to get money until Monday. During an interview on 10/18/23 at 3:14 PM, with Licensed Practical Nurse (LPN) #1, she confirmed she works every other weekend on the medication cart. LPN #1 said she has never seen an envelope with money on the medication cart. The nurse said the residents must get their money from the business office by Friday evening. During an interview on 10/19/23 at 9:05 AM, with the Director of Nursing (DON), she said when she	F 567	accommodate residents needs. Any concerns will be brought to Quality Assurance Performance Improvement Committee 11/16/23 for corrective action times three months.	

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first started working at the facility, the BOM would leave money in a black box on weekends on the medication cart. The DON said she has not seen the black box lately. She revealed she doesn't know where it's kept but knows it's not on the medication cart. The DON said she doesn't know if the BOM is leaving the money with the kitchen and doesn't know if the residents are able to get money on weekends now or not.

During an interview on 10/19/23 at 10:08 AM, with LPN #3, revealed she occasionally works on weekends. The nurse stated the business office does not give her an envelope with money for the residents to have over the weekend.

On 10/19/23 at 10:54 AM, during an interview with the Administrator, she stated the BOM should be leaving an envelope on the medication cart with $50.00 on Friday for the residents to use on the weekend. The Administrator revealed she did not know the money was not being left for the Residents to use of the weekends.

During an interview on 10/19/23 at 11:00 AM, with the Dietary Manager, she revealed the dietary department never receives resident funds for the weekend or any other time.

Resident #4

A record Review of Resident #4's "Admission Record" revealed the facility admitted the resident on 8/16/22, with diagnoses that included Lack of Coordination, Depression, and Malignant Neoplasm of Breast.

A record review of the Comprehensive Minimum Data Set (MDS) with Assessment Reference

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Date (ARD) 8/2/23 revealed a Brief Interview of Mental Status (BIMS) score of 14, which indicated resident was cognitively Intact.

Resident #11

A record Review of Resident #11's "Admission Record" revealed the facility admitted the resident on 7/26/22, with diagnoses that included Hypertension, Anxiety and Diabetes Mellitus.

A record review of Resident #11's Quarterly MDS with an ARD of 10/3/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #17

A record Review of Resident #17's "Admission Record" revealed the facility admitted the resident on 6/1/23, with diagnoses that included Heart Failure, Kidney Disease and Osteoarthritis.

A record review of Resident #17's Quarterly MDS, with an ARD of 8/23/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #18

A record Review of Resident #18's "Admission Record" revealed the facility admitted the resident on 5/25/22, which included diagnoses of Hypertension, Heart Failure and Diabetes Mellitus.

A record review of Resident #18's Quarterly MDS, with an ARD of 8/2/23, revealed a BIMS score of 15, which indicated the resident was cognitively

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intact.

Resident #20

A record Review of Resident #20's "Admission Record" revealed the facility admitted the resident on 10/21/20, with diagnoses that included Heart Disease, Hypertension and Lack of coordination.

A record review of Resident #20's Quarterly MDS, with an ARD of 9/11/23, revealed a BIMS score of 14, which indicated the resident was cognitively intact.

Resident #27

A record Review of Resident #27's "Admission Record" revealed the facility admitted the resident on 4/9/23, with diagnoses of Hypertension, Anxiety Disorder and Diabetes Mellitus.

A record review of Resident 27's Quarterly MDS, with an ARD of 8/14/23, revealed a BIMS score of 14, which indicated the resident was cognitively intact.

Resident #28

A record Review of Resident #28's "Admission Record" revealed the facility admitted the resident on 10/13/20, with diagnoses of Hypertension, Heart Failure and Anxiety Disorder.

A record review of Resident #28's Annual MDS, with an ARD of 8/11/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #30

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F 567	Continued From page 11 A record Review of Resident #30's "Admission Record" revealed the facility admitted the resident on 8/28/23, with diagnoses of Hypertension, Renal Disease and Anxiety. A record review of Resident #30's Quarterly MDS, with an ARD of 9/22/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Resident #31 A record Review of Resident #31's "Admission Record" revealed the facility admitted the resident on 2/15/23, with diagnoses of Hypertensive Urgency, Rheumatoid Arthritis and Anxiety Disorder. A record review of Resident' #31's Quarterly MDS, with an ARD of 9/13/23, revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment.	F 567		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		11/22/23

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§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all

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information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 14 decision. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure Resident Council complaints were resolved in a timely manner regarding transportation to outings. This affected nine (9) of (12) Resident council members who participate in the Resident Council meetings. Residents #4, #11, #17, #18, #20, #27, #28, #30 and #31 Findings Include: Review of the facility's policy titled, "Grievances and Complaints," dated 2/14/23, revealed, "Social services will act as the grievance officer for the facility and oversee the grievance process. Grievance forms should be kept outside of the office, where residents, and staff members can access them at any time. All grievances will be reported to Social Services and Social Services will follow the following procedure to investigate and work to resolve the grievance... STEP 1 Upon receipt of a grievance, Social Services will complete a written report within five working days of the filed grievance and determine what corrective action, if any should be taken... STEP 2 Social services must notify the person who filed the grievance, within 10 working days of the filed grievance, in the form of a report. Copies of this report will be available to the person at any time. STEP 3 If filer is not satisfied with the results of the investigation, the filer may file a report with the local ombudsman..." Review of the facility's policy titled, "Facility Assessment," reviewed 1/2023. revealed, "A facility assessment is conducted annually to	F 585	* Residents #4,#11,#17,#18, #20,#27,#28,#30,and #31 were assessed 11/01/2023 by Director of Nursing with no adverse findings. *All residents have the potential to be affected. *Meeting with Residents was held with Administrator and Social Worker on 11/10/23 to discuss facilities grievance procedure. Facility outings will be arranged quarterly by Life Connections Director with first outing on 12/20/23 for residents to stay connected with Community Activities. * All grievances will be reviewed weekly for 3 weeks beginning 11/03/23 by Administrator to determine if facility procedures are being followed. Grievances and Resident Council minutes will be reviewed by Social Services Director monthly for 3 months. Any concerns will be brought 11/16/23 to facilities Quality Assurance Performance Improvement Committee for corrective action times three months.	

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determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment .... 3. The facility assessment includes a detailed review of the resident's population. This part of the assessment includes: ... d. (3) activities ..."

Review of the facility's policy titled, "Life Connection Program," reviewed 3/2023 revealed, " Policy Statement: Life connections programs are designed to meet the interest of and support the physical, mental and psychosocial well-being of each resident. Policy Interpretation and Implementation: 1. The life connections program is provided to support the well-being of residents and to encourage both independence and community interactions ..."

Review of the facility's, "Admission Agreement" dated 1/20/09, revealed, " ...GRIEVANCES and/or CONCERNS (Resident) ... Policy Statement: It is the policy of this facility to support each resident's right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear or discrimination or reprisal. After receiving a concern/grievance, the facility will actively seek a resolution and keep the residents appropriately appraised of its progress toward a resolution. As necessary, the facility will take action to prevent further occurrences during the investigation ..."

Review of the facility's "Resident Rights," revised and implemented on November 28,2016, revealed, " ... (3) The resident has all right to interact with members of the community and

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participate in community activities both inside and outside of the facility ... (5) The resident has a right to organize and participate in residents groups in the facility ... (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility ... (8) The resident has the right to participate in other activities, including social, religious, and community activities that do not interfere with other residents in the facility ... (j) ... (2) The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph ..."

During a Resident Council meeting on 10/16/23 at 03:30 PM, with the Resident Council members, Residents #4, #11, #17, #18, #20, #27, #28, #30 and #31 complained that the facility van has not been available for over a year, as it is need of repair. The residents said in the past, they enjoyed going shopping, fishing, and taking part in community events. The residents said when the van was working, they were able to participate in different functions outside of the facility. However, since the van stopped working, they feel isolated. The residents also said they feel like inmates, as they are unable to leave the facility. The Activity Director has been shopping for them, but they prefer to look around the stores and choose for themselves. They were told this was their home, but they can't go out of the building to functions because they don't have transportation.

During an interview on 10/18/23 at 2:47 PM, with the Activity Director, she confirmed the residents have complained several times in the Resident

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Council meetings about the van being broken. The Activity Director said the residents want to go shopping for themselves. She explains to them every month the new shopping policy to remind them not to give money to staff to buy things. The Director revealed there are only two (2) people in the facility that can shop for the residents, her, and the Business Office Manager (BOM). The Director also said the residents complain about being stuck at the facility and not having transportation to go out to other events. The Activity Director said she talked to the Administrator about the residents' concerns about not going to outside events. The Administrator told her that is working with the corporate office to resolve the issue, but she doesn't know how long it would take.

During an interview on 10/18/23 at 3:00 PM, with the Social Worker revealed she was not told about the grievance of the van. The Social Worker stated she is aware the van has not been running for a long time, but neither the Activity Director, nor the residents have complained to her.

During an interview on 10/19/23 at 10:54 AM, the Administrator confirmed the van has not worked for over a year. The Administrator said she doesn't know the exact day the van stopped running. She stated she is working with the corporate office on a resolution. The Administrator commented the corporate office has not decided whether they're going to get the motor fixed in the van or buy another van. For now, the Administrator said the facility uses the local transportation company to make sure the residents can get to their doctor appointments. The Administrator confirmed that the facility has

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not rented a van or used transportation services for outside activity events for the residents. The Administrator revealed she doesn't know how long it will take for the corporate office to make a decision regarding the van.

Resident #4

A record Review of Resident #4's "Admission Record" revealed the facility admitted the resident on 8/16/22, with diagnoses that included Lack of Coordination, Depression, and Malignant Neoplasm of Breast.

A record review of the Comprehensive Minimum Data Set (MDS) with Assessment Reference Date (ARD) 8/2/23 revealed a Brief Interview of Mental Status (BIMS) score of 14, which indicated resident was cognitively Intact.

Resident #11

A record Review of Resident #11's "Admission Record" revealed the facility admitted the resident on 7/26/22, with diagnoses that included Hypertension, Anxiety and Diabetes Mellitus.

A record review of Resident #11's Quarterly MDS with an ARD of 10/3/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #17

A record Review of Resident #17's "Admission Record" revealed the facility admitted the resident on 6/1/23, with diagnoses that included Heart Failure, Kidney Disease and Osteoarthritis.

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A record review of Resident #17's Quarterly MDS, with an ARD of 8/23/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #18

A record Review of Resident #18's "Admission Record" revealed the facility admitted the resident on 5/25/22, which included diagnoses of Hypertension, Heart Failure and Diabetes Mellitus.

A record review of Resident #18's Quarterly MDS, with an ARD of 8/2/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #20

A record Review of Resident #20's "Admission Record" revealed the facility admitted the resident on 10/21/20, with diagnoses that included Heart Disease, Hypertension and Lack of coordination.

A record review of Resident #20's Quarterly MDS, with an ARD of 9/11/23, revealed a BIMS score of 14, which indicated the resident was cognitively intact.

Resident #27

A record Review of Resident #27's "Admission Record" revealed the facility admitted the resident on 4/9/23, with diagnoses of Hypertension, Anxiety Disorder and Diabetes Mellitus.

A record review of Resident 27's Quarterly MDS, with an ARD of 8/14/23, revealed a BIMS score of

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14, which indicated the resident was cognitively intact.

Resident #28

A record Review of Resident #28's "Admission Record" revealed the facility admitted the resident on 10/13/20, with diagnoses of Hypertension, Heart Failure and Anxiety Disorder.

A record review of Resident #28's Annual MDS, with an ARD of 8/11/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #30

A record Review of Resident #30's "Admission Record" revealed the facility admitted the resident on 8/28/23, with diagnoses of Hypertension, Renal Disease and Anxiety.

A record review of Resident #30's Quarterly MDS, with an ARD of 9/22/23, revealed a BIMS score of 15, which indicated the resident was cognitively intact.

Resident #31

A record Review of Resident #31's "Admission Record" revealed the facility admitted the resident on 2/15/23, with diagnoses of Hypertensive Urgency, Rheumatoid Arthritis and Anxiety Disorder.

A record review of Resident' #31's Quarterly MDS, with an ARD of 9/13/23, revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment.

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide the Resident, or the Resident Representative (RR), written notification of the bed hold policy at the time of transfer for one (1) of 15 sampled residents. Resident #39	F 625	*Resident #39 was assessed 11/02/2023 by Director of Nursing with no adverse findings. *All Residents have the potential to be affected. *In-service education was given to Social Worker and Business Office Manager and	11/22/23

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F 625	Continued From page 22 Findings include: A review of the facility's policy, "Bedhold Policy and Procedure", undated, revealed, "..Before the facility transfers a resident to the hospital ...written information should be provided to the resident and family member or legal representative specifying the following information ...The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the facility; and ...The policies regarding bed hold periods, which should be consistent ..." Resident #39 On 10/17/23 at 10:09 AM, during a phone interview with the RR, she stated that she did not receive written notification of the bed hold information regarding Resident #39's recent hospitalization. A review of the medical record revealed there was no written notification of the bed hold policy at the time of Resident #39's transfer from the facility on 7/25/23. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/25/23, revealed the resident was discharged to an acute care hospital on 7/25/23. A record review of the "Admission Record" revealed the facility initially admitted Resident #39 on 12/15/22 with a diagnosis of Dementia, and he was re-admitted on 7/28/23 with a diagnosis of Urinary Tract Infection.	F 625	Nursing Staff on 11/02/23 by Administrator on facilities procedure for Bed Hold notification to resident and family before going to hospital. * Bed hold and transfer forms will be reviewed weekly beginning 11/03/23 by Administrator for 3 weeks then Monthly for 4 months. Any concerns will be brought 11/16/23 to facilities Quality Assurance Performance Improvement Committee for corrective action times three months.	

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A record review of the Quarterly MDS with an ARD of 6/23/23 revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated he had severe cognitive impairment.

On 10/17/23 at 10:15 AM, an interview with the Admissions Coordinator (AC), revealed she reviewed the subject of the Bed hold with the Resident and/or RR at the time of admission. The AC revealed she explained to the RR that in the event of hospitalization, they may hold the Resident's bed for a daily charge. The AC reported the admissions packet, which included the bed hold form, was sent to the Business Office when completed.

On 10/17/23 at 10:20 AM, an interview with the Business Office Manager (BOM), revealed she received the admissions packet, included the bed hold form from the AC and filed the form in her office. The BOM stated that at the time of a resident hospitalization, she called the RR to ask if they wanted to hold the Resident's bed and discussed payment at that time. She confirmed she did not provide written notification to the Resident or the RR at the time of the hospital transfer.

On 10/17/23 11:58 AM, an interview with the Social Services Director (SSD) revealed that when a resident is transferred or discharged to the hospital, she mailed the RR a notification of transfer and that she did not provide written notification of bed hold at the time of resident transfer to the hospital.

On 10/19/23 at 07:37 AM, during an interview with the Administrator, she acknowledged the

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F 625	Continued From page 24 failure of the facility to provide written notification to the Resident or RR of the bed hold policy at the time of each hospitalization. The Administrator reported that this was a learning experience for her staff.	F 625		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility's policy review, the facility failed to ensure a resident who was dependent on staff assistance for showering received those services for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL) assistance. Resident #10 Findings include: A record review of the facility's policy "Bath, Shower/Tub," dated August 25, 2014, revealed " ... The purposes of this procedure are to promote cleanliness, provide comfort to the resident ... The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath ... 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken."	F 677	*Resident #10 received her shower 10/19/23 at 6:43p.m. 100% of Bath Schedules were audited Director of Nursing and RN Supervisor on 10/20/23 to assure each resident had a bath or shower schedule. Resident #10 was set up to be given a bath Monday, Wednesday, and Friday on 3:00p.m.-11:00p.nm.shift *All Residents have the potential to be affected. * In-service education was provided by Director of Nursing to Nurses and Certified Nursing Assistants on 10/30/2023 regarding Bath schedules and how to document if Resident got one or where to put notes if resident didn't to state why. * Bath Schedules will be checked weekly beginning 10/23/23 times 4 weeks then Monthly times 3 Months by Director of Nursing and/or RN Supervisor for all new admissions, re-admissions or room moves to make sure each resident has a	11/22/23

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F 677	Continued From page 25 On 10/16/23 at 12:30 PM, during an interview and observation, Resident #10 was observed in her wheelchair, with toiletry supplies in her hand. It was noted that the resident's hair looked dirty and oily. The resident explained it has been a week ago Monday since she had her last shower. She stated she is to take a shower three (3) times a week on the evening shift. Resident #10 revealed she goes to the shower with a Certified Nursing Assistance (CNA), as she is afraid of falling and needs assistance. On 10/17/23 at 8:15 AM, observed and interviewed Resident #10 lying in bed. The resident was alert and oriented. The resident explained she did not receive a shower last night. Her hair continues to look dirty and oily. On 10/17/23 at 10:10 AM, during an interview with CNA #1, she explained she does not have Resident #10 today but reported she has worked with the resident. CNA #1 revealed that the resident gets showers on the evening shift and the assistance of one person is required. The CNA commented that Resident #10 has never refused any care on her, especially a shower. She stated that Resident #10 loves to take showers. On 10/17/23 at 10:25 AM, during an interview with CNA #2, she explained Resident #10 is given baths/showers on evening shifts and sometimes resident may get washed off in the mornings but gets showers on the evening shift. On 10/17/23 at 3:40 PM, during an interview with CNA #3, she explained Resident #10 is scheduled for evening showers and she seldom has had Resident #10 on her care load, but	F 677	bath schedule in place. Weekly totals will be brought 11/16/23 to facilities Quality Assurance Performance Improvement meeting times three months. Any discrepancies will have corrective action in place.	

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Resident #10 rarely refused showers on her.

On 10/17/23 at 4:20 PM, during an interview with CNA #4, she explained the facility has a shower binder to help with who gets showers and when, but reported the showers are listed in the Kiosk under task for the CNAs to complete. The CNA revealed that Resident #10 always wants to go to the shower, seldom refuses, and she thought Resident #10 went to the shower last night. While reviewing the task record with the CNA, the record revealed the resident refused her shower, however, CNA #4 confirmed that she doesn't remember the refusal. The CNA then commented that she will try and give the resident a shower tonight. She explained the shower binder is only an extra source for quick review of the showers. CNA #4 confirmed that Resident #10's hair appears dirty and oily.

On 10/17/23 at 4:30 PM, during an interview with Resident #10, she explained she does not remember staff asking her about a shower last night. She revealed she has seldom refused showers, except for last week when she had a doctor's appointment on Wednesday and was just too tired to go to the shower.

On 10/17/23 at 4:45 PM, during an interview with Registered Nurse (RN) #1, she explained if a resident frequently refuses care, a care plan meeting should be arranged with the resident and family and should be care planned for refusal. The RN confirmed Resident #10's hair looked dirty and oily.

On 10/18/23 at 7:30 AM, Resident #10 was observed sitting in the foyer area, the resident's hair continued to look dirty. The resident reported

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she still did not get a shower last night, and no one came and asked her.

On 10/19/23 at 11:35 AM, during an interview with the Administrator, she explained she expects her staff to provide showers as scheduled consistently.

At 11:40 AM on 10/19/23, during an interview with the Director of Nurses (DON), she explained she expects all staff to respect resident's wishes, give showers as scheduled and chart if the resident refused.

Record review of Resident #10's "Admission Record" revealed the facility admitted the resident on 8/02/22 with the diagnoses of Malignant Neoplasm of Colon, Chest Pain, and Need for Assistance for Personal Care.

Record review of Resident #10's Annual Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 7/20/23, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Further review of the MDS revealed that showers are somewhat important to the resident and the resident had no rejection of care. The MDS also revealed that bathing did not occur during the timeframe of the MDS documentation.

Record review of the Resident #10's Point Click Care "Documentation Survey Report" for July-2023 through October-2023 revealed an intervention/task for bathing M-W-F (Monday-Wednesday-Friday) 3-11. For the month of July 2023 Resident #10 missed seven (7) showers for the month. For the month of August 2023, Resident #10 missed three (3)

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F 677	Continued From page 28 showers for the month. For the month of September 2023, Resident #10 missed two (2) showers for the month. For the month of October 2023 Resident #10 missed two (2) showers and refused once.	F 677		
F 812 SS=F	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 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, interview, record review, and facility policy review, the facility failed to thaw food at the correct temperature, failed to clean the equipment according to the cleaning schedule, and failed to ensure the three compartment sinks' chemical sanitation was working appropriately to prevent possible foodborne illnesses for two (2) of four (4) dietary observations. This has a potential to affect all	F 812	* The food was discarded by Dietary Manager and replaced on 10/16/23. Equipment was cleaned by Dietary staff and Dietary manager on 10/19/23. three compartment sink was checked by Maintenance Supervisor on 10/18/23 and was working correctly once adjusted. Eco Lab came and inspected three compartment sink on 10/19/23 and	11/22/23

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residents receiving meals prepared by the facility's dietary department.

Findings Include:

Review of the facility's policy titled, "Meat Cookery and Storage," from Crandall Corporate Dietitians (Copyright ©2020), revealed, "the Food and Nutrition Services Department should ensure that meat shall be prepared in a manner to preserve quality, maximize nutrient retention and to obtain maximum yield of product ...Procedure: Meat which needs defrosting should be pulled three days prior to service and defrosted in a dry, cool area at 41 degrees F (Fahrenheit) or less. Larger meats, such as whole turkey may require additional thawing time. Date meat when pulled for defrosting ..."

Review of the facility's in-service dated 9/22/23 revealed the dietary staff was in-serviced on "Cooling Monitor for Hazardous Foods."

Review of the facility's in-service dated 9/25/23 revealed the dietary staff was in-serviced on the proper way to store food. The in-service included a document titled, "Food Storage," from Crandall Corporate Dietitians," (Copyright ©2019), which revealed, "Improper storage of Time/Temperature Controlled for Safety (TCS) foods can affect your budget or even worse, get a resident sick ... b. Fresh raw poultry should be kept in a refrigerator that maintains 40 degrees F (Fahrenheit) or below and used with 1-2 days. c. Improper storage of food is the main reason for foodborne illness ..."

Review of the facility's policy titled, "Cleaning Schedules" from Crandall Corporate Dietitians

verified it was working correctly.
*All Residents have the potential to be affected.
*In-service education was given on 11/07/23 to all dietary staff by Dietary Manager regarding proper way to thaw food correctly, Proper use of 3 compartment sink and cleaning schedules.
*Dietary Manager will observe beginning 10/23/23 Thawing of food, and proper use of three compartment sink 3 times a week for 3 weeks then 1 time weekly for 3 weeks. Cleaning schedules will be checked 3 times a week for completion and inspection then 1 time weekly for 3 weeks. Documentation will be brought 11/16/23 to facilities Quality Assessment Performance Improvement Committee monthly times 3 months. Any Concerns will be discussed and Corrective action will be taken if needed.

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(Copyright ©2018), revealed "The Food and Nutrition Services staff shall maintain sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinical qualified nutrition professionals ... Community satellite kitchens will be able to be held to the same sanitary standards as the main kitchen, utilizing a comprehensive cleaning schedule specific to each kitchen ... Procedure: 1. The Director of Food and Nutrition Services or other qualified nutrition professionals shall record all cleaning sanitation tasks for the Food and Nutrition Services Department. 2. A cleaning schedule shall be posted with task designated to specific positions in the department. 3. All tasks shall be addressed as to frequency of cleaning ... 6. On the "Position" cleaning schedules the Director of food and Nutrition Services or other clinically qualified nutrition professional fills in the Position, the item to be clean, Frequency, i.e. daily, day of week, or week 1, 2, 3, 4. 7. Under the days of the week or the weeks, the Director of Food and Nutrition Services or other clinically qualified nutrition professional can check off assignments completed, or the employee can initial ..."

A record review of the facility's, "Daily and Weekly Cleaning Schedule," revealed schedules dated 9/31/23-10/8/23, 10/9/23-10/13/23 and 10/18/23-10/22/23 staff initials were present indicating the grill/ovens, range/catch pan, steam table/tray lines, and pots and pans sink had been cleaned each day.

A record review of the facility's document titled, "Sanitizer Use Concentrations for Food Service

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and Food Production Facilities," from Crandall Corporate Dietitians (Copyright ©2020), revealed, " ... a. A chlorine solution shall have a minimum temperature and contact time based on the concentration and pH (acidity or basicity) of the solution as listed in the following chart: Concentration Range 25 ppm (parts per million) with a 10 second contact time, 50 ppm with a seven (7) second contact time, and 100 ppm with a 10 second contact time ... d. A hot water sanitize shall have a minimum temperature and contact time based on equipment specifications as listed in the following chart: ... a. Equipment Specifications ...3-compartment (three-compartment) sink integral heating device immersed in rack or basket ... Minimum Temperature ...171 degrees F ...Minimum Contact Time 30 (thirty) seconds."

Review of the facility's, in-service, dated 6/27/23, revealed the dietary staff received an inservice that included "Review of Sanitation."

An initial tour of the kitchen on 10/16/23 at 11:40 AM, with the Dietary Manager (DM), revealed six (6) bags of chicken in zip lock bags were soaking in water in the three-compartment sink, thick grease and grime was noted on the side of the stove, a thick grease substance around the edge of the steam table lids and a thick calcium build up was in the steam table compartment pans. The Dietary Manager (DM) said the lids are cleaned every shift but food spill on them because they are stored underneath the steam table where food is served. The DM revealed that the chicken had been soaking in the water since 10:30 AM.

During an interview on 10/16/23 at 11:45 AM, with

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Dietary Worker/Cook #2, she explained the chicken is thawing in the sink for Wednesday's lunch.

During an interview on 10/17/23 at 12:08 PM, with the DM confirmed the chicken was soaking in the water. The DM said that Dietary Aide #3 put the chicken in the water to thaw, as he was trying to prep for Wednesday.

An observation on 10/17/23 at 12:15 PM, revealed Dietary Worker/Cook #5 washing pots in the three-compartment sink. The Dietary Worker washed the pots and pan in soapy water and rinsed them with clear water, then placed with the clean pots and pans. The pots and pans were not sanitized.

During an interview with Dietary/Cook #5 on 10/17/23 at 12:31 PM, she confirmed she washed the pots and pans and rinsed them off without sanitizing them. The Dietary Worker revealed the sanitizer did not work. She explained when they turn on the sanitizer, the water runs from the back of the dispenser to the floor. Dietary Worker #5 said the sanitizer has been broken for a week and a half to two weeks and states that it has been reported to the DM.

During an interview on 10/17/23 at 1:00 PM, with the Registered Dietitian (RD), she revealed she works at the facility on Mondays and Tuesdays. The RD revealed that she was unaware that there was a problem with the sink and sanitizer on the three-compartment sink. The RD revealed she thought the staff was cleaning the stove at least monthly and confirmed the facility should have been cleaning and sanitizing the steamed table lids and steam table compartments daily to

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prevent cross contamination, food borne illnesses. The RD confirmed the chicken should not have been soaked in water to thaw, as the chicken should have been thawed in the refrigerator or with running water over it to prevent the chicken from causing foodborne illnesses which could cause the residents to get sick. The RD explained that by not sanitizing the pots and pans appropriately, it could also cause foodborne illnesses.

In an interview on 10/17/23 at 1:30 PM, with the DM he stated that Dietary Worker #3 put the chicken in the water to thaw because he was trying to help the cooks to have the chicken ready for Wednesday. The DM confirmed the chicken should have been left in the refrigerator to thaw or it should have had cold running over the chicken to prevent the chicken from getting too warm and possibly cause a food borne illness to the residents and staff. The DM stated that the monthly cleaning schedule for the stove is done by the night cook. He revealed he doesn't remember when the last time the cook cleaned the stove, but he thinks it was between two and three months ago. The manager confirmed the stove had thick greasy grime and build up all over it and needed to be cleaned to prevent fires and cross contamination. The DM also confirmed he was notified Friday of last week (10/13/23) at 9:00 AM, that the sanitation on the three-compartment sink was not working appropriately. The DM stated that the water was running down onto the floor whenever the sanitation was turned on. The DM also explained that the staff was told to turn it on only to allow the sanitation in the water during the time needed and to make sure it was turned off afterwards to prevent it from leaking onto the floor. The DM stated that he was told at that time

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that the leaking had occurred a week and half prior to his knowledge. The DM revealed that he had called the local dishwashing company and notified them of the leaking. The DM also confirmed the steam table lids had grease build up and grime around the edge of the lids. The DM stated that the lids are cleaned daily but because they are housed under the steam table it causes food and other things to drop on the lids. The DM further confirmed the compartments on the steam table had extra calcium and grime buildup.

During an interview on 10/17/23 at 1:45 PM, the Administrator revealed she did not know that the sink was broken and running water continuously. The Administrator also said she did not know that the sanitation system on the three-compartment sink was not working until today. The Administrator confirmed that by not sanitizing the pots and pans, it could cause foodborne illnesses in the facility. The Administrator also stated that she did not know the staff were soaking the chicken in water to thaw. The Administrator stated that she expects the kitchen to follow the approved dietary guidelines to prevent foodborne illnesses. The Administrator also revealed that she had not been in the kitchen for a while and did not know that the stove had not been cleaned. The Administrator stated that the DM is responsible for the cleaning schedule and making sure it is followed by the dietary staff.

During an interview on 10/17/23 at 2:00 PM, with the Maintenance Director he revealed he was unaware that the sink was continuously running and would not stop, nor was he unaware that sanitation was not working appropriately in the three-compartment sink was The Maintenance Director stated that he does not deal with the

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three-compartment sink, as the local dishwashing company does not want anyone else to perform maintenance on their equipment. The Maintenance Director stated that the facility is responsible for putting equipment issues in the maintenance log and he signs off on them when they are finished. The Maintenance Director revealed that he would fix the sink today as soon as possible.

During an interview on 10/17/23 at 2:30 PM, with Dietary Worker/Cook #4, he revealed he cooks at night. The cook confirmed it has been between five (5) and six (6) months since he cleaned the stove. He also confirmed the compartments and lids on the steam table should have been cleaned. He revealed that when he washed the pots and pans, he ran the sanitizer in the sink and then turned it off, to stop the water from running onto the floor. Dietary Worker #4 confirmed the sanitation system has been broken for two weeks and it had been reported to the Dietary Manager.

During an interview on 10/18/23 at 9:10 AM, with Dietary Worker #3, he confirmed he put the chicken in the water to thaw, as he was trying to help the cooks get prepared for Wednesday. Dietary Worker #3 revealed he did not know that thawing chicken submerged in water could cause a foodborne illness.