STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. BUILDING _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CARE CENTER OF MARION	6434 A DALE DR MARION, MS 39342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility on 7/8/24 through 7/11/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F641, F685, F804, F812, F883 and F887. The facility held a license for 120 beds with a census of 78.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (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. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		8/16/24

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

Electronically Signed | 07/25/2024

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F 565	Continued From page 1 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review the facility failed to ensure resident council members' complaints regarding food that was served cold were recorded and resolved in a timely manner for nine (9) of 11 Resident council members. (Resident #4, #18, #20, #27, #42, #49, #52, #62, and #68) Findings include: Review of the facility's policy, "Resident and Family Grievances" revised 6/1/23 revealed, "... It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal ...Policy Explanation and Compliance Guidelines ...8. Grievances may be voiced in the following forums ...d. Verbal complaint during resident or family council meetings ...10. Procedure ...d. The Grievance Official will take steps to resolve the grievance ...e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances ...12. The facility will make prompt efforts to resolve grievances ..."	F 565	Upon notification a food substitution was immediately offered to those residents affected. Social Service Assistant visited residents on 7/12/24 to ensure the issue with the temperature of the food served was resolved and acceptable. Social Services Assistant also completed follow-up interviews with residents on 7/25/24. There were no current food service complaints and everything was better. All Residents have the potential to be affected by the deficient practice. The social services assistant(SSA) was in serviced on collecting minutes for the resident council meeting(RCM) and reviewing them with the resident council president(RCP). After reviewing, SSA will have RCP to sign in agreement of what was discussed before meeting is adjourned. SSA will email concerns to administrator no later than 2 days after RCM. The SSA will follow up with resolution x7 days or until concerns have been resolved.	

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F 565	Continued From page 2 Review of the "Resident Council Minutes" dated 6/27/24 revealed the resident council members complained the nurses take too long to come to the dining room during lunch and dinner and the residents complained the food was cold because of the wait. The "Recommendations/Solutions" dated 7/1/24 revealed an in-service was conducted on dining room times with staff and the dining room schedule was posted on each unit and with the receptionist. Review of January through June 2024 of resident council meeting minutes revealed the June 2024 minutes was the only month in which complaints regarding food being served cold were recorded. During the Resident Council Meeting on 7/8/24 at 2:00 PM, the members revealed they had complained for several months, not just June 2024, that the food was served cold for all meals. They explained they originally thought the problem was with the nurses coming to the dining room timely and therefore causing the food to be served cold, however, the problem had not been resolved since the nurses had been coming to the dining room timely. The members said they expected the Social Services Assistant (SSA) to record all their complaints every month and share them with the Dietary Manager (DM) and the Administrator. During an interview on 7/11/24 at 10:21 AM, the SSA explained she was responsible for writing the resident council meeting minutes and confirmed the residents had complained for several months that the meals were served cold. She said she was unsure why the residents' complaints were not included in the April 2024 and May 2024 minutes and determined she may have forgotten	F 565	Old minutes will be reviewed, by the social services assistant, beginning on 7/26/24.The SSA will review minutes with RCP x 12 weeks beginning on the day prior to the August 2024 resident council meeting to ensure concerns are being resolved and or addressed. New and Unresolved concerns will be discussed, and decesions made regarding resolution, with department managers associated with concerns and administrator on the date following each resident council meeting. This process will begin on the day after the resident council meeting of August 2024. All RCM will be reviewed in the monthly Quality Assessment and Assurance Committee meeting monthly for 3 months beginning August 15, 2024 to ensure sustained compliance.	

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to record them. The SSA reported that she had placed the residents' complaints in the DM's box and did not provide a copy for the Administrator. The SSA explained the residents' complaints regarding cold food had been discussed several times during daily stand-up meetings with the interdisciplinary team.

During an interview on 7/11/24 at 10:45 AM, with the Director of Nursing (DON), she confirmed she was aware the residents had complained food was served to them cold and was told it was because the nurses were late coming to the dining room. She explained she then began posting nursing assignments indicating which nurses were to serve in the dining room and she had been observing to ensure the nurses were not late getting to the dining room. She confirmed the resident's complaints regarding cold food had been discussed during stand-up meetings.

In an interview on 7/11/24 at 11:13 AM, with the Assistant Dietary Manager, she stated she was unaware the residents were complaining the food served was cold and she had not received any complaints from the resident council for the month of June. She explained the Dietary Manager was not at the facility this week and had not advised her there were complaints regarding cold meals served to the residents. She stated she had recently been attending stand up meetings and was not aware there was any discussion during those meetings that the residents were complaining the food was served to them cold.

During an interview on 7/11/24 at 11:18 AM, the Administrator confirmed the residents had

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previously complained the food was cold and he had instructed Dietary services to serve the dining room first and then serve the residents who complained of cold food on the halls. He had thought the complaints were resolved and was unaware the residents in resident council continued to complain the food was served cold. He stated he had not been given a copy of the resident council meetings for June 2024.

Resident #4

A record review of the Admission Record revealed the facility admitted Resident #4 on 8/18/23.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/24 revealed Resident #4 had a Brief Interview for Mental Status (BIMS score of 15, which indicated she was cognitively intact.

Resident #18

A record review of the Admission Record revealed the facility admitted Resident #18 on 4/17/23.

A record review of the Quarterly MDS with an ARD of 6/13/24 revealed Resident #18 had a BIMS score of 14, which indicated she was cognitively intact.

Resident #20

A record review of the Admission Record revealed the facility admitted Resident #20 on 11/9/22.

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A record review of the Quarterly MDS with an ARD of 6/27/24 revealed Resident #20 had a BIMS score of 10, which indicated his cognition was moderately impaired.

Resident #27

A record review of the Admission Record revealed the facility admitted Resident #27 on 3/9/22.

A record review of the Quarterly MDS with an ARD of 6/19/24 revealed Resident #27 had a BIMS score of 15, which indicated he was cognitively intact.

Resident #42

A record review of the Admission Record revealed the facility admitted Resident #42 on 3/7/18.

A record review of the Quarterly MDS with an ARD of 5/9/24 revealed Resident #42 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #49

A record review of the Admission Record revealed the facility admitted Resident #49 on 1/8/24.

A record review of the Quarterly MDS with an ARD of 5/2/24 revealed Resident #49 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #52

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F 565	Continued From page 6 A record review of the Admission Record revealed the facility admitted Resident #52 on 7/5/23. A record review of the Annual MDS with an ARD of 6/12/24 revealed Resident #52 had a BIMS score of 15, which indicated he was cognitively intact. Resident #62 A record review of the Admission Record revealed the facility admitted Resident #62 on 12/28/22. A record review of the Quarterly MDS with an ARD of 5/23/24 revealed Resident #62 had a BIMS score of 11, which indicated her cognition was moderately impaired. Resident #68 A record review of the Admission Record revealed the facility admitted Resident #68 on 1/19/24. A record review of the Quarterly MDS with an ARD of 4/18/24 revealed Resident #68 had a BIMS score of 15, which indicated she was cognitively intact.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		8/16/24

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F 641	Continued From page 7 by: Based on staff interview, record review, and facility policy review, the facility failed to accurately complete the Minimum Data Set (MDS) assessments for residents who were discharged from the facility for two (2) of 18 residents reviewed. (Resident #77 and Resident #79) Findings include: A review of the facility's policy "Conducting an Accurate Resident Assessment", dated 11/6/23 revealed, " ... The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas ... Definition: "Accuracy of assessment" means that the appropriate, qualified health professionals correctly document ...using the appropriate Resident Assessment Instrument (RAI) ..." Resident #77 A record review of the "Admission Record" revealed the facility admitted Resident #77 on 3/13/24 with current diagnoses including Hemiplegia and Hemiparesis. A record review of the Discharge MDS with an Assessment Reference Date (ARD) of 4/10/24 revealed Resident #77 was discharged from the facility to a nursing home (long-term care facility). A record review of a "Progress Note", dated 4/10/24, revealed Resident #77 was transferred to an acute care hospital and not a long-term care facility.	F 641	The Minimum Data Set (MDS) of Resident #77 and #79 was modified on 07/09/24. All residents have the potential to be affected by the deficient practice. The MDS Nurses were in-service on correct coding of the MDS by the Director of Nursing (DON) on 07/17/24. The DON will audit the MDS of residents who are discharged weekly x 12 weeks for accuracy beginning on 07/22/24. All audits will be reviewed by the Quality Assurance and Assessment Committee monthly x 3 months beginning 08/15/24 to ensure sustained compliance.	

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Resident #79

A record review of the "Admission Record" revealed the facility admitted Resident #79 on 3/20/24 with current diagnoses including Type 2 Diabetes Mellitus.

A record review of the Discharge MDS with an ARD of 4/22/24 revealed Resident #79 was discharged from the facility to a short-term general hospital.

A record review of the "Discharge Summary and Instructions", dated 4/22/24, revealed Resident #79 was discharging to a nursing home (long-term care) facility per the family's request.

A record review of the "Progress Notes", dated 4/22/24 at 11:20 AM, revealed Resident #79 was discharged to a long-term care facility and not a short-term general hospital.

At 3:40 PM on 7/9/24, during an interview with Licensed Practical Nurse (LPN) #2/MDS Nurse, she explained Resident #79 went to a long-term care facility when he was discharged. She also explained Resident #77 was discharged to an acute hospital when he left the facility. LPN #2 reviewed Resident #77's and #79's Discharge MDS and confirmed the MDS assessments were not accurate and explained she was unsure how the error had occurred.

At 11:50 AM on 7/11/24, during an interview with the Director of Nursing (DON), she explained she was made aware of the inaccuracy of the MDS assessments, and the facility was working on making corrections regarding Resident #77 and

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F 641	Continued From page 9 Resident #79. She stated she expected all residents to have accurate MDS assessments.	F 641		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure vision services were provided for a resident who was visually impaired for one (1) of 15 sampled residents. Resident #4 Findings include: A review of the facility's policy, "Social Services Policy" revised 6/1/23 revealed, "Policy: The facility ...will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...Policy Explanation and Compliance Guidelines ...4. The social worker ...will pursue the provision of any identified need for medically-related social services of the resident ...Services to meet the resident's needs	F 685	Facility failed to ensure vision service was provided for residents #4 who was vision impaired. "Resident #4 was made an appointment for her glasses to be fitted on 07/26/2024. Prescriiption glasses were obtained for this residnt on 7/26/24 All Residents have the potential to be affected by the deficient practice. Inservices regarding obtaining eye glasses, hearing devices or other treatment devices were started on 7/25/24. On 7/22/24 a 100% audit was started on all residents who had an optometry appointment within the last six months to	8/16/24

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F 685	Continued From page 10 may include ...d. Making arrangement for obtaining items, such as adaptive equipment, clothing, and personal items ...g. Making referrals and obtaining needed services from outside entities ..." On 7/8/24 at 2:47 PM, during an interview and observation, Resident #4 reported she had lost her prescription glasses and the facility had provided her with a pair of reading glasses from a local retail store. She was unsure when she had lost the glasses and was unsure if she had reported it to the facility. She explained she enjoyed reading but was unable to use the glasses provided by the facility because she could not see through them, and it was difficult to read. The resident was not wearing glasses. On 07/10/24 at 9:18 AM, an interview with Social Services Director (SSD) revealed Resident #4 had reported to her that she could not afford the prescription glasses that had been prescribed to her in April. The resident advised the SSD that she could not see well, so the SSD went to a local retail store and purchased a pair of over the counter reading glasses for the resident. The SSD reported she did not seek assistance for the resident in attaining new prescription glasses through any alternative community support agencies and she did not consult with the Administrator regarding the resident's inability to pay for the new prescription glasses. On 7/10/24 at 10:00 AM, in an interview with the Director of Nursing (DON), she acknowledged Resident #4 had a new prescription in her medical record for glasses that she received when she had an eye exam on 4/8/24. The DON reported the prescription was not filled because	F 685	ensure all residents with vision deficient needs were met as of 7/30/24. All optometry appointments will be audited by the Director Of Nursing x 12 weeks to ensure all orders are complete and all resident vision needs are met. Audit findings will be brought to the Quality Assurance Committee monthly x 3 months starting on 8/15/2024 to ensure sustained compliance.	

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the resident did not have the money in her account to pay for them. The DON confirmed the facility did not secure other means to assist the resident in having her new prescription filled and the Administrator was not informed that the resident was unable to afford the new glasses.

On 07/10/24 at 10:15 AM, an interview with the Administrator revealed he had not been informed Resident #4 was unable to pay for new prescription glasses. The Administrator reported that the facility had occasion to purchase glasses and dentures for residents who were not able to afford them. The Administrator stated, although it was not the policy of the facility to broadly purchase glasses for all residents, if there was a need, the facility would assess the resident's ability to pay for services and would assist accordingly. The Administrator reported his expectation going forward was to get the residents what they needed to provide a better quality of life for them.

A record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #4 on 8/18/2023 with diagnoses including Hypothyroidism.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/29/24 revealed in Section B that Resident #4 had corrective lenses and in Section C the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

A record review of the Admission MDS with an ARD of 8/24/23 revealed it was "very important" for Resident #4 to have books, newspapers, and

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F 685	Continued From page 12 magazines to read. Record review of an eyeglass prescription, dated 4/8/24, revealed Resident #4 had visual impairment in both eyes that required corrective lenses.	F 685		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility's policy review the facility failed to ensure resident's food was served at an appetizing temperature for one (1) of 15 sampled residents. This had the potential to affect 74 residents receiving food from the kitchen. (Resident # 38) Findings include: A review of the facility's policy "Food Preparation Guidelines" dated 10/5/22 revealed, " ... The facility will prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status ... Definitions ..."Proper (safe and appetizing) temperature" means both appetizing to the resident and minimizing the risk for scalding and burns ... Policy Interpretation and	F 804	Dietary Manager in Training immediately spoke with Resident #38 about food palatability and temperature concerns. A followup conversation regarding these concerns occured on 7/25/24. Resident stated" everything is now acceptable and just like she likes it". All residents who eat by mouth have the potential to be affected by this deficient practice. The meal delivery system was modified so that the cart service for in-room dining now uses more carts with fewer trays going out on each cart. The cook now immediately puts the insulated lid onto the plate instead of waiting for the tray aid to	8/16/24

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F 804	Continued From page 13 Implementation ...3. Food and drinks will be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include: ... c. Serving hot foods/drinks hot and cold foods/drinks cold ..." This tag is cross referenced to the tag F565: 1. Based on observation, interviews, record review, and facility policy review the facility failed to ensure resident council members' complaints regarding food that was served cold were recorded and resolved in a timely manner for nine (9) of 11 Resident council members. (Resident #4, #18, #20, #27, #42, #49, #52, #62, and #68) On 7/8/24 at 12:30 PM, during an observation of two (2) lunch meal trays, the meal consisted of fried pork chop, pinto beans, turnip greens, corn bread, fruited gelatin, tea and water. The Administrator brought the two trays directly from the kitchen and the food was cold to taste and touch. On 7/8/24 at 2:18 PM, during an interview with Resident#38, she complained she is currently upset at the facility because she had issues with staff not wanting to reheat her food. She complained her breakfast was always cold and she was tired of it because it had been going on for a while. At 11:15 AM on 7/9/24, during an interview with Resident #38, she explained her breakfast was cold again this morning and she had to get someone to reheat the food. On 7/9/24 at 11:28 AM, during an observation and interview with Dietary #2/Cook, he prepared the	F 804	place the insulated lid after condiments have been added. Dietary staff were in-serviced on 07/22/24 by CDM regarding meal temperature, serving in a timely manner and food palatability. Nursing staff were in-serviced on 07/25/24 by staff development on ensuring meal temperatures are acceptable, meals are delivered timely and alternatives to resolve resident concerns regarding meal temperatures that include reheating and/or providing another tray from the kitchen. . The CDM or Designee will interview 5 residents a week x 12 weeks to ensure food is served at a palatable temperature. This audit began on 7/26/24. Audit findings will be brought to the Quality Assurance Committee monthly x 3 months starting on 8/15/24 to ensure sustained compliance.	

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F 804	Continued From page 14	F 804		

meal trays to be served to residents in the dining room. He stated he cannot prepare meal trays for the residents on the hall until all residents in the dining room were served. At 11:42 AM, the cook began preparing the meal trays for the halls. At 11:57 AM, one of the dietary aides began placing meal trays onto the cart but stopped because she had to prepare more silverware for the trays. At 12:00 PM, Dietary #2 had to stop preparing hall trays to make more mechanical soft meat loaf for the residents, and Dietary #1 continued preparing the trays for the residents on the hall.

On 7/9/24 at 12:11 PM, during an observation, the last tray cart was sent to the last hall with two (2) test trays on the cart. The tray cart was an open metal tray cart that was not insulated. There were three (3) insulated carts pushed to the side and one (1) insulated tray cart that did not have a door. The open tray cart was pushed to the hall by a Dietary Aide and Dietary #1 and explained the Certified Nurse Aides (CNAs) on the hall would pass out the trays to the residents. After four (4) minutes a CNA started to pull trays and pass them out to the residents.

At 12:23 PM on 7/9/24, during an interview and observation, Dietary #1 tested the temperature of the last tray on the last cart. The temperatures were the following: country meatloaf 80 degrees Fahrenheit (F); garlic mashed potatoes 100 F; buttered green peas 84 F; pork cutlet 80 F; stewed tomatoes 90 F and steamed rice 84 F. The temperatures of the individual food items had dropped from country meatloaf 170 F; garlic mashed potatoes 170 F; buttered green peas 164 F; pork cutlet 160 F, stewed tomatoes 135 F; and steamed rice 170 F. The food on the two test

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trays were tasted by the State Agency (SA) and Dietary #1 and was cold and not at an appetizing temperature. Dietary #1 explained the food was at room temperature, but confirmed it was cold. She explained if she was served the food at a restaurant, she would send it back because the food was not hot enough for her to eat.

At 1:10 PM on 7/9/24, during an interview with CNA #1, she explained Resident #38 had complained that her food was cold, and it had been reported to the kitchen staff several times.

During an interview on 7/11/24 at 11:18 AM, with the Administrator, he confirmed the residents had complained the food was cold. He had dietary to started serving the dining room first and then serve the residents on the hall that were complaining first. He thought the complaints were resolved, and he did not know the resident's council continued to complain in June. He expected all residents to be served food at an appetizing temperature.

Resident #38

A record review of the "Admission Record" revealed the facility admitted Resident #38 on 11/19/18 with diagnoses including Bipolar Disorder and Anxiety Disorder.

A record review of the "Order Summary Report" with active orders as of 7/9/24, revealed Resident #38 had a Physician's Order, dated 5/3/24, for a Regular diet, Regular texture, and Regular consistency with chopped ham and turkey.

A record review of the Annual Minimum Data Set

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F 804	Continued From page 16 (MDS) with an Assessment Reference Date (ARD) of 5/9/24, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated she was cognitively intact.	F 804		
F 812 SS=D	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, staff interview, and facility policy review, the facility failed to ensure the chemical sanitizer for a low-temperature dishwasher had a concentration of at least 50 parts per million (ppm) for one (1) of two (2) dishwasher observations. Findings Include:	F 812	The chemical sanitizer was connected to the dish machine and primed so that the sanitizer came out in the correct amount. This was done on 7/9/24 immediately when the issue was discovered. Sanitizer was tested using the chemical test strip and verified to be at the correct parts per million.	8/16/24

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F 812	Continued From page 17 Review of the facility's policy," Sanitization" with a revision date 10/04/22, revealed, "The food service area will be maintained in a clean and sanitary manner. Policy Interpretation and Implementation ...3. All equipment, food contact surfaces and utensils will be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and or chemical sanitizing solutions ...6. Dishwashing machines must be operated using the following specifications ...Low-Temperature Dishwasher (Chemical Sanitization) ...b. Final rinse with 50 parts per million (ppm) hypochlorite (chlorine) for at least 10 seconds ..." On 7/9/24 at 11:08 AM, during an observation and interview of the tray line, Dietary #2/Cook was preparing trays for the residents in the dining room. Dietary #2 frequently stopped the line and placed dishes to the side. He stated that upon inspection, the dishes were not clean. There were 12 small bowls, five (5) plates, three (3) large serving bowls, and one (1) platter set aside. Some of the dishes had large amounts of dried food on them and some of them had small specks of food residue on them. On 7/9/24 at 1:48 PM, in a follow-up interview with Dietary #2, he stated he thought the dishwasher was not cleaning the dishes properly and explained that he never used soiled dishes when preparing meal trays for the residents. On 7/9/24 at 1:59 PM, in an interview with Dietary #1/Assistant Dietary Manager, she confirmed the facility had problems with the dishwasher and it had been rebuilt approximately two (2) months ago. She explained they had minor problems with the dishwasher which required a repairman to	F 812	All residents who eat by mouth have the potential to be affected by this deficient practice. All dietary employees were in-service by the assistant dietary manager on ensuring that chemicals are dispensing properly before starting the wash cycle and when chemicals are changed. This was completed on 7/12/2024. Beginning 7/26/24 dishwasher will be checked daily to ensure that sanitizer is dispensing at 50 parts per million before starting the first cycle of dishwashing and when the sanitizer bottle is changed. Results will be recorded by dietary personnel. CDM, assistant manager or administrator will check solution once weekly or at chemical change x 12 weeks beginning 7/29/24. Results will be recorded by dietary personnel. Audit findings will be brought to the Quality Assurance Committee monthly x 3 months starting on 8/15/2024 to ensure sustained compliance.	

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F 812	Continued From page 18 come to the facility to repair it. She reported it was the responsibility of the dietary aides to check the dishes before the dishes were stored to make sure they were clean. On 7/9/24 at 2:10 PM, in an observation with Dietary #1 and Dietary #3, there were four (4) dirty plates. Dietary #3 sprayed the dishes and placed them in the low temperature dishwasher. After the dishwasher cycle ended, she removed the plates, and they had specks of food residue on them. The dishwasher temperature reached 130 degrees Fahrenheit (F), which was within the required temperature range and the chlorine measured 10 ppm on the dish surface, which was less than 50 ppm. Dietary #1 confirmed the plates were not clean and the sanitation was less than the required amount. On 7/9/24 at 2:25 PM, in an interview with the Corporate Dietary Consultant, she stated the sanitation had been changed earlier today and was not coming through the tubing properly because the tubing had not been primed. She stated that after priming the tubing, the sanitation reading was 50 ppm. On 7/11/24 at 1:00 PM, in an interview with the Administrator, he stated he was made aware the dietary staff had not primed the sanitation tubing after installing a new container of sanitation in the dishwasher and explained that education and training had begun immediately for the dietary staff as soon as the issue was observed.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883		8/16/24

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F 883	Continued From page 19 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 883		

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F 883	Continued From page 20 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide evidence that residents refused the Influenza and/or Pneumococcal vaccine for two (2) of five (5) residents reviewed for immunizations. Resident #22 and Resident #37 Findings include: A review of the facility's policy, "Vaccination of Residents", dated 8/2/22, revealed, " ...All residents will be offered vaccines ...Policy Interpretation and Implementation 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations ...2. Provision of such education shall be documented in the resident's medical record ...5. If vaccines are refused, the refusal shall be documented in the resident's medical record ..." Resident #22	F 883	Residents #22 and #37 were offered the Influenza and Pneumococcal vaccine on 07/17/24 and a new consent or declination form obtained. All Residents have the potential to be affected by the deficient practice. The Infection Preventionist Nurse was in-serviced on obtaining Vaccination consent or declination forms by the Director of Nursing (DON) on 07/17/24. The DON will audit all new admissions weekly x 12 weeks to verify that the resident has been offered vaccinations and the consent or declination form is obtained. Results of the audits will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting monthly for 3 months beginning 8/15/24 to ensure sustained compliance.	

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F 883	Continued From page 21	F 883		

A record review of the facility's "Transfer/Discharge Report" revealed the facility admitted Resident #22 on 11/22/23 with diagnoses including Hemiplegia and Hemiparesis.

A review of the medical record revealed there was no documentation that indicated Resident #22 had received or refused an influenza and pneumococcal vaccination.

Resident # 37

A record review of the facility's "Transfer/Discharge Report" revealed the facility admitted Resident #37 on 09/22/23 with diagnoses including Chronic Atrial Fibrillation.

A review of the medical record revealed there was no documentation that indicated Resident #22 had received or refused an influenza and pneumococcal vaccination.

On 7/10/24 at 10:15 AM, in an interview with the Director of Nursing (DON), she stated Resident #22 and Resident #37 had refused the influenza and pneumococcal vaccines. She confirmed the facility did not have a signed copy of the declination or refusal forms for Resident #22 and Resident #37 in their medical records. The DON explained the Resident Care Coordinator (RCC) was responsible for ensuring immunization records were available in the resident's medical record.

On 7/11/24 at 11:00 AM, in an interview with the Administrator, he acknowledged he was aware the facility was unable to provide evidence Resident #22 and Resident #37 had refused

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F 883	Continued From page 22 influenza and pneumococcal immunizations. The Administrator stated the RCC was responsible for maintaining immunization documents in the medical records and expected the RCC to have documentation available as required. On 07/11/24 at 11:37 AM, in an interview with the RCC, she confirmed she was unable to provide declination forms or documentation of refusal for Resident #22 and Resident #37 regarding the influenza and pneumococcal immunizations. The RCC confirmed she was responsible for maintaining the immunization records and she planned to begin scanning the documents herself to ensure they are properly added to the medical record.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination	F 887		8/16/24

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F 887	Continued From page 23 requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide	F 887	Residents #22 and #37 were offered the COVID-19 vaccine on 07/17/24 and a new	

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F 887	Continued From page 24 evidence that residents refused the COVID-19 vaccine for two (2) of five (5) residents reviewed for immunizations. Resident #22 and Resident #37 Findings include: A review of the facility's policy, "Vaccination of Residents", dated 8/2/22, revealed, " ...All residents will be offered vaccines ...Policy Interpretation and Implementation 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations ...2. Provision of such education shall be documented in the resident's medical record ...5. If vaccines are refused, the refusal shall be documented in the resident's medical record ..." Resident #22 A record review of the facility's "Transfer/Discharge Report" revealed the facility admitted Resident #22 on 11/22/23 with diagnoses including Hemiplegia and Hemiparesis. A review of the medical record revealed there was no documentation that indicated Resident #22 had received or refused a COVID-19 vaccination. Resident # 37 A record review of the facility's "Transfer/Discharge Report" revealed the facility admitted Resident #37 on 09/22/23 with diagnoses including Chronic Atrial Fibrillation.	F 887	consent or declination form obtained. All Residents have the potential to be affected by the deficient practice. The Infection Preventionist Nurse was in serviced on obtaining Vaccination consent or declination forms by the Director of Nursing (DON) on 07/17/24. Beginning on 7/29/24 the DON will audit all new admissions weekly x 12 weeks to verify that the resident has been offered vaccinations and the consent or declination form is obtained.Results of the audits will be monitored and reviewed in the monthly Quality Assessment and Assurance Committee meeting monthly for 3 months beginning 8/15/24 to ensure sustained compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255328	A. BUILDING _____ B. WING _____	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 887	Continued From page 25	F 887		

A review of the medical record revealed there was no documentation that indicated Resident #22 had received or refused a COVID-19 vaccination.

During an interview on 7/10/24 at 10:15 AM, the Director of Nursing (DON), she stated Resident #22 and Resident #37 had refused COVID-19 vaccines. She confirmed the facility did not have a signed copy of the declination or refusal forms for Resident #22 and Resident #37 in their medical records. The DON explained the Resident Care Coordinator (RCC) was responsible for ensuring immunization records were available in the resident's medical record.

During an interview on 7/11/24 at 11:00 AM, with the Administrator, he stated he was aware the facility was unable to provide evidence Resident #22 and Resident #37 had refused COVID-19 vaccines. The Administrator stated the RCC was responsible for maintaining immunization documents in the medical records and expected the RCC to have documentation available as required.

In an interview on 07/11/24 at 11:37 AM, with the RCC, she confirmed she was unable to provide declination forms or documentation of refusal for Resident #22 and Resident #37 regarding COVID-19 vaccines. The RCC confirmed she was responsible for maintaining the immunization records and she planned to begin scanning the documents herself to ensure they were properly added to the medical record.