STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING _____ B. WING _____	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	2041 GRAND AVE YAZOO CITY, MS 39194

(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 re-certification survey with one (1) complaint, CI MS# 25378, at the facility from 9/24/24 through 9/26/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F 656 related to implementataion of Comprehensive Care Plan and F 677 related to Activities of Daily Living (ADL) care for CI MS#25378. The SA also cited F 641, F 645, F 812, and F 880. The census at the time of the survey was 56 and the facility is licensed for 60 beds.	F 000		
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 by: Based on record review, staff interviews, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for discharge deposition for one (1) of 15 elder assessments reviewed. Elder #58 Findings included: Record review of Facility Policy titled, "Conducting an Accurate Resident Assessment" revealed, "Policy: The purpose of this policy is to assure that all residents receive an accurate assessment..." Record review of the "Notice of	F 641	1. The Minimum Data Set (MDS) coordinator was in-serviced by the Director of Clinical Support on September 25, 2024, on the importance of accuracy in MDS assessments. MDS for Resident #58 was corrected and retransmitted on September 25, 2024. An audit of the discharge assessments for the previous 30 days prior to September 25, 2024 was performed by the MDS Coordinator and reviewed by the Director of nursing. This was completed on October 6,2024. 2. All elders have the potential to be affected by this deficient practice. 3. All MDS discharge assessments done	11/1/24

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

Electronically Signed | 10/10/2024

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F 641	Continued From page 1 Transfer/Discharge Notice" dated 7/29/24, for Elder #58 revealed that the elder discharged to an alternative nursing home. Record review of Elder #58's Discharge return not anticipated MDS, with an Assessment Reference Date (ARD) of 7/29/24, revealed discharge status was coded as 04, indicating that the elder was discharged to a Short-Term General Hospital. During an interview with the MDS Coordinator on 9/25/24 at 10:47 AM, she confirmed that Elder #58 discharged to another long-term care facility and that the MDS was coded incorrectly. She stated it was a data entry error. She agreed that the importance of correctly coding the MDS accurately is to identify where the resident is located. An interview with the Administrator on 9/25/24 at 11:00 AM, revealed the MDS should have been coded correctly. Record review of the "Admission Record" revealed that facility admitted Elder #58 on 6/18/24 with a diagnosis of Diabetes Mellitus.	F 641	for the next 3 weeks, beginning on September 30, 2024, will be reviewed by another MDS nurse prior to submission. Thereafter, one dishcharge MDS assessment will be reviewed prior to submission each month until December 31, 2024. 4. Director of Nursing (DON) and Administrator will monitor all discharge MDS assessments weekly for four weeks beginning on September 30, 2024, to ensure accuracy of coding for disposition at discharge. They will continue to monitor discharge assessments for accuracy on a monthly basis until December 31, 2024. A Quality Assurance and Performance Improvement (QAPI) committee meeting will be held on November 1, 2024, to review the results of these audits and revise the Plan of Correction (POC) if additional concerns are identified. The POC will be reviewed at each monthly QAPI meeting thereafter until December 31, 2024.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		11/1/24

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F 645	Continued From page 2	F 645		

authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

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F 645	Continued From page 3 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and facility policy reviews, the facility failed to submit a correct Pre-Admission Screening and Resident Review (PASRR) for an Elder identified as having a mental illness. This issue involved one (1) of three (3) elders reviewed for PASRR. Elder #8. Findings Included: A review of the facility's policy titled "Resident Assessment-Coordination with PASARR Program" revealed: "This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated setting appropriate to their needs."	F 645	1. The Medical Records nurse was educated on September 25, 2024, by the Director of Clinical Support and the Administrator as to the importance of confirming the final approval for all Preadmission Screening and Resident Review (PASARR) forms once submitted. The PASARR for Resident #8 was edited and resubmitted as a significant change on September 25, 2024. Approval was confirmed on October 2, 2024. All PASARR submissions for all elders with mental illness (MI) or intellectual disability (ID) diagnoses were verified as correctly submitted by the Minimum Data Set (MDS) Coordinator on September 30, 2024. 2. All elders (with mental illness (MI) or intellectual disability (ID) diagnoses have	

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F 645	Continued From page 4 A record review of the PASRR, dated 12/27/23, for Elder #8 revealed that he had a diagnosis of Schizophrenia; however, question 31 was answered "no," indicating that the Elder did not have a history of mental illness. Further review of the "Pre-Admission Screening and Resident Review Determination (PASRR)" for Elder #8 revealed the following outcome: "Level 1 Outcome: Closed-Canceled/Withdrawn. Level 1 Outcome Comments: This PASRR will be canceled due to lack of documentation available to support the individual's diagnoses. A status change can be submitted upon retrieval of further information to support the individual's diagnoses." During an interview with Medical Records on 9/25/24 at 12:30 PM, confirmed that the PASRR had been completed incorrectly by indicating that Elder #8 did not have a mental illness. She also verified that there was no indication that a status change had been submitted to correct the error. In an interview with the Administrator on 9/25/24 at 1:16 PM, she agreed that a status change should have been submitted for Elder #8. She acknowledged that the purpose of a PASRR is to ensure the resident is properly placed and to make sure that the resident receives any additional interventions they may need. A review of the Admission Record revealed that the facility admitted Elder #8 on 12/19/23 with a diagnosis of Schizophrenia. Record review of the Minimum Data Set with an Assessment Reference Date of 9/13/24 Section I revealed a diagnosis of Schizophrenia.	F 645	the potential to be affected by this deficient practice. 3. The primary nurse responsible for submission of PASARR forms will monitor all submissions for acceptance for the next 3 weeks, beginning on September 25, 2024. After that, she will monitor all submissions for acceptance once monthly until December 31,2024. 4. Minimum Data Set Coordinator (MDS) and Director of Nursing will review all new admissions in the next 3 weeks, beginning September 30, 2024, for MI or ID diagnoses and will review the PASARR screenings prior to submission to ensure accuracy. They will then select one admission for review monthly until December 31, 2024, to verify accuracy. A Quality Assurance and Performance Improvement (QAPI) committee meeting will be held on or before November 1, 2024, to review and revise the Plan of Correction (POC) if additional concerns are identified. The POC will be reviewed at each monthly QAPI meeting thereafter until December 31, 2024.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		11/1/24

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F 656	Continued From page 5 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 6 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, elder and staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for nail care for two (2) of sixteen sampled elders. Elder #7 and #31 Findings Include: Review of the facility policy titled "Comprehensive Care Plans" date implemented 10/2022 revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Resident #31 Record review of Elder #31's Care Plan with a revision date of 9/11/2024 revealed, "Focus: Elder has an ADL (activities of daily living) self-care performance deficit r/t (related to) impaired balance, musculoskeletal impairment cervical disc disorder with myelopathy, paraplegia." Also, revealed under, "Interventions:... Personal Hygiene... Elder is totally dependent on staff for	F 656	1. A 100% audit of all care plans requiring that an elder be assisted with Activities of Daily Living (ADLs), specifically nail care, was performed by the Minimum Data Set (MDS) coordinator and Registered Nurse (RN) clinical coordinators and completed on October 8, 2024. For any elder with this requirement, a task specifying nail care was added to the documentation system for that elder's direct caregivers. 2. All elders who require assistance for ADLs, specifically nail care, have the potential to be affected by this deficient practice. 3. All direct caregivers were in-serviced on the importance of routine nail care as a part of daily hygiene beginning September 25, 2024. Beginning the week of October 6, 2024, Licensed Practical Nurse (LPN) Charge Nurses will document nail conditions with each weekly body audit for all elders, to ensure that care plans are being followed. LPN will perform nail care for any diabetic elders prior to or during the weekly body audit. 4. RN Clinical Coordinators will perform audits of nail care for all elders weekly for 4 weeks, beginning the week of October 6, 2024, then monthly until December 31,	

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F 656	Continued From page 7 personal hygiene ... x (times) 1 staff assist q (every) shift. Keep nails clean and trimmed." On 9/24/24 at 11:25 AM, an observation and interview with Elder #31 revealed long jagged fingernails on both hands measuring approximately three-eighths (3/8) inch in length with a dark brown substance underneath. The elder revealed he would like his nails cut. An interview and observation, with Registered Nurse (RN) #1, on 9/24/24 at 11:32 AM confirmed Elder #31's nails were long and dirty. Record review of the "Admission Record" revealed the facility admitted Elder #31 on 1/05/24 with a medical diagnosis of Cervical Disc Disorder with Myelopathy. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/02/24 revealed, under section C, a BIMS summary score of 15, which indicated Elder #31 was cognitively intact. Resident #7 Record review of Elder #7's Care Plans revealed "Focus: Elder has an ADL (activities of daily living) self-care performance deficit r/t (related to) Alzheimer's, confusion, dementia, limited mobility, bilateral contractures lower ext (extremities)." Also, revealed under, "Interventions: ... Personal Hygiene ... Elder is totally dependent on (2) staff for personal hygiene .... Provide nail care, keep clean and trimmed." An observation and interview, on 9/24/24 at 11:40 AM, with Elder #7 revealed long fingernails	F 656	2024. A Quality Assurance and Performance Improvement (QAPI) committee meeting will be held on November 1, 2024, to review results of the RN audits and revise the Plan of Correction (POC) if additional concerns are identified. The POC will be reviewed at each monthly QAPI meeting thereafter until December 31, 2024.	

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F 656	Continued From page 8 observed on both hands, measuring approximately one-half (1/2) inch in length. The elder voiced it had been a while since her nails had been cut and revealed she would like it done. On 9/25/24 at 7:40 AM, an interview with RN #1 confirmed Elder #7's nails were long and needed to be cut. Record review of the "Admission Record" revealed the facility admitted Elder #7 on 11/02/21 with a medical diagnosis of Alzheimer's Disease. Record review of the MDS with an ARD of 8/5/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Elder #7 was moderately cognitively impaired. In an interview with the MDS Nurse on 9/25/24 at 2:32 PM, she stated the care plan provides the guided care the staff were supposed to follow. She confirmed the care plan was not followed, related to nail care for Elder's #7 and #31.	F 656		
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 observation, elder and staff interview, and facility policy review, the facility failed to provide the necessary nail care for an elder dependent on staff for assistance with Activities of	F 677	1. Nails were cleaned and trimmed for Elder #7 and Elder #31 on September 24, 2024. A 100% audit of the nails of all elders was also performed on September	11/1/24

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F 677	Continued From page 9 Daily Living (ADL) for two (2) of sixteen sampled elders. Elder #7 and #31 Findings Include: Review of the facility policy titled, "Nail Care" dated 10/2022 revealed, "Policy: The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health... 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis ...." Resident #31 During an observation and interview on 9/24/24 at 11:25 AM, with Elder #31 revealed long jagged fingernails on both hands measuring approximately three-eighths (3/8) inch in length with a dark brown substance underneath. The elder revealed he would like his nails cut. On 9/24/24 at 11:32 AM, an interview and observation with Registered Nurse (RN) #1 revealed the Shahbaz's were responsible for cutting the elder's nails that were not diabetic. She explained that if an elder was a diabetic, the nails must be cut by a RN and diabetic nails were usually cut monthly. RN #1 revealed Elder #31 was a diabetic and confirmed his nails were long and dirty, which could result in skin injury and infection. Record review of the "Admission Record" revealed the facility admitted Elder #31 on 1/05/24 with a medical diagnosis of Cervical Disc Disorder with Myelopathy. Record review of the Minimum Data Set (MDS)	F 677	24, 2024. Any nails noted to be overly long or unclean were trimmed and cleaned accordingly at that time. 2. All elders who require assistance for nail care have the potential to be affected by this deficient practice. 3. All direct caregivers were in-serviced on the importance of routine nail care as a part of daily hygiene beginning September 25, 2024. Registered Nurse (RN) Clinical Coordinators, Minimum Data Set (MDS) Coordinator and Director of Nursing will monitor the documentation for nail care of 3 elders in the electronic medical record (EMR) weekly for 3 weeks, beginning October 6, 2024. Licensed Practical Nurse (LPN) Charge Nurses will document nail conditions for all elders with each body audit, done weekly, beginning the week of October 6, 2024. LPN will perform nail care for any diabetic elders prior to or during the weekly body audit. 4. RN Clinical Coordinators will perform audits of nail care for all elders weekly for 4 weeks, then monthly until December 31, 2024. A Quality Assurance and Performance Improvement (QAPI) committee meeting will be held on November 1, 2024, to review the results of the RN audits and revise the Plan of Correction (POC) if additional concerns are identified. The POC will be reviewed at each monthly QAPI meeting thereafter until December 31, 2024.	

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F 677	Continued From page 10 with an Assessment Reference Date (ARD) of 7/02/24 revealed, under section C, a BIMS summary score of 15, which indicated Elder #31 was cognitively intact. Resident #7 During an observation and interview, on 9/24/24 at 11:40 AM, with Elder #7 revealed long fingernails observed on both hands, measuring approximately one-half (1/2) inch in length. The elder voiced it had been a while since her nails had been cut and revealed she would like it done. An interview with RN #1 on 9/25/24 at 7:40 AM, confirmed Elder #7's nails were long and revealed she could easily scratch herself. Record review of the "Admission Record" revealed the facility admitted Elder #7 on 11/02/21 with a medical diagnosis of Alzheimer's Disease. Record review of the MDS with an ARD of 8/5/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Elder #7 was moderately cognitively impaired. An interview with the Administrator (ADM) on 9/25/24 at 1:48 PM, revealed, it was her expectation for nail care to be done daily. She explained that nail care was part of personal hygiene and should be looked at during bathing and done when needed.	F 677		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		11/1/24

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F 812	Continued From page 11 §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, record review, and facility policy review, the facility failed to maintain a clean and sanitary refrigerator, label, and date open items in the refrigerator and freezer for one (1) of six (6) houses and failed to check and record food temperatures before serving meals for four (4) of six (6) houses reviewed during survey. Findings Include: House #5 Review of the facility policy titled, "Cleaning of Food and Nonfood Contact Surfaces" with a revision date of 1/24, revealed under, "Food Contact Surfaces ... To prevent cross -contamination, kitchenware and food-contact	F 812	1. A 100% audit of all food storage areas for cleanliness was performed on September 24, 2024. All food storage areas and appliances were ensured to be clean and sanitized at that time. Any food items noted that were noted without labels or improperly stored were discarded at this time. 2. All elders have the potential to be affected by this deficient practice. 3. The Shahbazim were in-serviced beginning on September 24, 2024, as to their responsibility for keeping all food storage areas clean and sanitary on a continuous basis. They were also in-serviced regarding the required labeling (with date indicated) for all opened bulk food items, and regarding the appropriate	

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F 812	Continued From page 12 surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred." Also revealed, "Food Contact Surfaces" (meaning: those surfaces of equipment and utensils which food normally comes in contact, and those surfaces from which food may drain, drip, or splash back onto food or surfaces normally in contact with food.) Review of the facility policy titled "Dating and labeling of Food in Production" undated, revealed under, "Standard: All foods, including prepared items, bulk foods, frozen foods, and ingredients present in a (Proper Name) facility must be labeled at all times. Foods requiring a date mark shall be labeled with the common name, preparation date, discard date, and associate initials." Initial tour of the kitchen at House # 5 on 9/24/24 at 11:55 AM, revealed a white refrigerator in the pantry area contained an empty, brown, cardboard egg crate in the bottom of the refrigerator that was observed to be wet with a white substance. The shelf above held two (2) containers of milk that were not stored in an upright position which resulted in milk leaking into the bottom of the refrigerator and on the egg carton. An observation on 9/24/24 at 12:06 PM, of the refrigerator in the kitchen area of the House #5 revealed a dark red liquid that covered the interior bottom of the refrigerator pull out crisper drawer. The top crisper drawer contained a large package [5 pounds (lbs.)] of sliced cheese with a torn blue wrapper that was undated and was dried out and	F 812	storage of items within the pantry and refrigerator/freezer. All Shahbazim were also educated as to the recording of food temperatures in the logbook for every meal without exception. 4. Dietician, Registered Nurse (RN) Clinical Coordinators and Shahbaz Guide will audit the food storage areas of each Green House for cleanliness weekly for 4 weeks, beginning September 30, 2024, then monthly until December 31, 2024. Any bulk food items noted will be checked for appropriate labeling during these audits. The dietician, RN Clinical Coordinators and Shahbaz Guide will also audit temperature logs of each Green House for completion during these audits, on a weekly basis for 4 weeks, then monthly until December 31, 2024. A Quality Assurance and Performance Improvement (QAPI) committee meeting will be held on November 1, 2024, to review the results of these audits and revise the Plan of Correction (POC) if additional concerns are identified. The POC will be reviewed at each monthly QAPI meeting thereafter until December 31, 2024.	

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hard around the edges. The freezer side of the refrigerator held a large clear plastic bag of tater tots that had been opened and was unlabeled and undated.

An interview with Shahbaz #3 on 9/24/24 at 12:11 PM, revealed that anyone could clean out the refrigerators when they were dirty and needed cleaning. She explained the red substance in the kitchen refrigerator crisper drawer was blood from raw ground beef that had been stored until it was cooked for lunch today. She stated, "It must have leaked out of the bag." Shahbaz #3 confirmed the sliced cheese was not any good and should be thrown away. She revealed the cheese, and the tater tots had been opened and were not labeled and dated but should have been. She confirmed the pantry refrigerator had spilled milk that had saturated the lower refrigerator. Shahbaz #3 revealed all the issues identified could make the Elder's sick.

House #1, #2, #4, and #6 Temperature Logs

Review of the facility policy titled, "Food Handling Guidelines (HACCP) Hazard analysis and critical control points," with a revision date of 1/24, revealed Minimum Safe Internal Temperatures: Hot food temperatures must be checked before the cooking process is ended. ... Hot Holding Temperatures: Foods should be held hot for service at a temperature of 135 degrees or higher. ... Cold Holding Temperatures: Foods should be held cold for service at a temperature of 41 degrees or less. ...

Record review of the September 2024 "Food Temperature Logs" for House # 1 revealed the breakfast and lunch meal temperatures were not

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logged for the dates of 9/2, 9/9, 9/10, 9/16, and 9/23. The facility was unable to account for the meal temperature logs for the dates of 9/3, 9/4, 9/5, 9/6, 9/7, 9/8, 9/11, 9/12, 9/13, 9/14, 9/15, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/24, and 9/25.

Record review of the September 2024 "Food Temperature Logs" for House # 2 revealed the lunch and dinner temperatures were not logged for 9/1, 9/2, 9/7, and 9/8. The dinner temperatures were not logged for the following dates 9/3, 9/4, 9/5, 9/9, 9/10, 9/11, 9/12, 9/13, 9/14, 9/15, 9/16, 9/17, 9/18, 9/19, 9/20, 9/21, 9/22, 9/23, and 9/24.

Record review of the August 2024 "Food Temperature Logs" for House #4 revealed the breakfast and lunch meal temperatures were not logged for the dates of 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20, and 8/21. The facility was unable to account for the meal temperature logs from 8/22/24 until 9/25/24.

On 9/24/24 at 12:00 PM, at House #4 an interview with Shahbaz #2 revealed she did not check the food temperatures for the lunch meal today. She revealed that she was sure she was trained to check the temperatures but confirmed she had not been checking them for any meal she had cooked in a long time.

Record review of the September 2024 "Food Temperature Logs" for House #6 revealed the Dinner temperatures were not logged for the following dates 9/14, 9/16, 9/18, and 9/20. On 9/15 and 9/17 the temperatures were not logged for breakfast, lunch, or dinner. On 9/19 the temperatures were not logged for lunch and dinner. The facility was unable to account for the

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meal log for the dates of 9/1-9/13, 9/21, 9/22, and 9/23.

An interview with Shahbaz #4 on 9/25/24 at 10:38 AM, in House # 6 revealed the food temperatures were to be checked before serving each meal and logged. She confirmed there was missing documentation in the logbook to prove that the temperatures were being checked with each meal. She explained that staff do the temperatures out of habit and then forget to log it down because they get busy and forget. Shahbaz #4 confirmed, if it is not logged, there would be no way to ensure that it was done.

An Interview with Shahbaz #1 on 9/24/24 at 12:05 PM, revealed she was not safe certified and had no knowledge of checking the holding food temperatures. She voiced that she was not trained in that.

An interview with the Registered Dietician (RD) on 9/25/24 at 12:51 PM, revealed that the Shahbaz's were trained upon hire on the duties in the kitchen including taking and logging holding food temperatures, cleaning and the storage of food products. He revealed this was part of their job responsibilities. He revealed each house has a safe serve certified Shahbaz that does the cooking. The RD confirmed that the food holding temperatures should be checked before serving every meal. He revealed all Shahbaz's were trained, and they have also had in-services on ensuring foods were labeled and dated when they opened. He revealed the blood left in the refrigerator crisper tray was not acceptable and should have been cleaned at the point it was observed. The RD confirmed these things discussed could make the elders sick. He stated,

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F 812	Continued From page 16 "It could cause food poisoning, at the very least some upset stomachs." He then revealed he was unable to find any food temperature logs for the Month of September 2024 for House #4 and found blanks in the temperature logs for Houses #1, #2, and #6. In a follow-up interview with the RD on 9/25/24 at 3:05 PM, revealed the facility does not have any forms that the house's document the cleaning of the refrigerators. He revealed he audits the houses at least monthly for cleanliness, storage of items, items labeled and dated, and the problems were reported to the Administrator and the Shahbaz Coordinator. An interview with the Administrator (ADM) on 9/25/24 at 1:48 PM, revealed that they were making audits on the houses weekly to ensure the food temperatures were being done and logged but had since changed to monthly. She revealed the Shahbaz's knew that when things were opened, they must be labeled and dated and voiced they all had been in-serviced on this. She confirmed that when the refrigerator needed cleaning because of a spill, it should be cleaned and not left for someone else. The ADM explained that they go over all these things and the kitchen responsibilities monthly in the Shahbaz meeting. She confirmed that these issues discussed could cause spoilage of food or an infection for the Elders.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		11/1/24

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 18 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to use hand hygiene during wound care to prevent the possibility of the spread of infection for one (1) of four (4) care observations. Elder #44 Findings Include: Review of the facility policy titled "Clean Dressing Change" with no revision date revealed under, "Policy: It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination."	F 880	1. The Licensed Practical Nurse (LPN) who performed wound care for the affected elder was in-serviced by the Director of Nursing (DON) on September 25, 2024, as to the proper technique and the policy related to dressing changes. The affected elder's wound was assessed on September 26, 2024, by the wound care physician. No signs or symptoms of infection or irritation were noted to the wound during this evaluation. 2. All elders requiring wound care have the potential to be affected by this deficient practice. 3. Beginning on September 25, 2024, all	

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F 880	Continued From page 19 Record review of Elder #44's Treatment Administration Record (TAR) for September 2024, revealed an order dated 9/24/24, "Apply collagen powder to wound bed. May dampen collagen powder with normal saline before application. Apply sureprep to peri area around wound, cover with bordered dressing daily until healed. every day shift for sacral wound". An observation of sacral wound care for Elder #44, with Licensed Practical Nurse (LPN) #1 on 9/25/24 at 11:40 AM, revealed she removed the soiled dressing from the sacrum and continued the treatment to the wound without performing hand hygiene and applying a new pair of gloves. An interview with LPN #1 on 9/25/24 at 11:47 AM, confirmed she did not wash her hands after removing Elder #44's soiled dressing. LPN #1 revealed she should have washed her hands to ensure the wound did not get infected. An interview with the Infection Control Nurse on 9/25/24 at 3:36 PM, confirmed improper hand hygiene during wound care was an infection control concern and could cause a wound infection. Record review of the "Admission Record" revealed the facility admitted Elder #44 on 2/09/21 with medical diagnoses that included Unspecified Dementia and Pressure Ulcer of Sacral region stage 3.	F 880	nurses that might be required to perform wound care (both registered nurses and licensed practical nurses) were required to attend an in-service with the Director of Nursing (DON) related to wound care and infection control. A competency check-off for wound care technique and infection control protocols was completed by all these nurses as of October 6, 2024. 4. Infection Prevention and Control Registered Nurse (RN) or Director of Nursing will monitor wound care performance weekly for one elder for 4 weeks beginning October 6, 2024, then monthly until December 31, 2024, to ensure that procedures and techniques for wound care are followed appropriately. A Quality Assurance and Performance Improvement (QAPI) committee meeting will be held on November 1, 2024, to review and revise the Plan of Correction (POC) if additional concerns are identified. The POC will be reviewed at each monthly QAPI meeting thereafter until December 31, 2024.	