MSDH - Health Facilities Licensure and Certification

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 48HM | A. BUILDING: _____ B. WING _____ | 05/15/2025 |

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| CARE CENTER OF ABERDEEN | 505 JACKSON ST ABERDEEN, MS 39730 |

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| M 000 | Initial Comments<br><br>The State Agency (SA) conducted an annual recertification survey and complaint investigation (CI) MS# 28988 at the facility from 05/12/25 through 05/15/25. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M500, M610, M640 and M815. The SA investigated complaint CI MS#28988 related to an allegation of residents rights with no deficiency cited.<br>The census at the time of the survey was 91 and the facility held a license for 105 beds. | M 000 | | |
| M 500 | 45.17.2 Residents' Rights<br><br>Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:<br><br>1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;<br><br>2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;<br><br>3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his | M 500 | | 6/2/25 |

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| M 500 | Continued From page 1<br>medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;<br><br>4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;<br><br>5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; | M 500 | | |

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| M 500 | Continued From page 2<br>6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;<br><br>7. is free from mental and physical abuse;<br>8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;<br>9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;<br><br>10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;<br><br>11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;<br><br>12. may associate and communicate privately with persons of his choice, may join with other | M 500 | | |

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| M 500 | Continued From page 3<br>residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);<br><br>15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and<br><br>16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.<br><br>This Statute is not met as evidenced by:<br>Level II<br>Based on resident and staff interviews, record review, and facility policy review, the facility failed | M 500 | On 05/15/2025 Licensed Social Worker (LSW) opened a grievance for Resident #247 and an investigation was initiated per | |

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| M 500 | Continued From page 4<br>to address and resolve a resident grievance related to timely Activities of Daily Living (ADL) care for one (1) of 20 sampled residents. Resident #247<br><br>Findings include:<br><br>Review of the facility policy titled "Grievances-Resident" with a revision date of 05/24 revealed, "All residents are to be encouraged and assisted (if necessary) in filing grievances to include those with respect to care and treatment, the behavior of staff ... The Administrator or Designee has been appointed as the Grievance official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusion, leading any necessary investigation by the facility ...Upon receipt of a grievance/complaint the staff receiving the complaint will report to their supervisor, grievance official, or will initiate the Grievance/Complaint Form NS-795."<br><br>Resident #247<br><br>Record review of "Grievance/Complaint" with an effective date of 03/24/2025, 3. Name of Staff who received this Complaint. (Name of Social Worker/Internet Review left by family member) revealed under Explanation/Nature of Complaint, "...Well my sister (Resident 247) had an issue a little while back when she came to visit. I cut my call light on and asked to be changed when she (Name of CNA)(Certified Nursing Assistant) came in. CNA responded, "You'll have to wait til I get back from my lunch." Her sister responded, "So she's just supposed to sit in this while you go to lunch and then she got changed."<br><br>On 5/12/25 at 11:00 AM, an interview with | M 500 | facility Grievance Policy. Grievance was resolved on 05/15/2025.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>On 05/15/2025 an in-service was initiated for all staff by the Director of Nursing (DON) and/ or Staff Development Registered Nurse on facility Grievance Policy. All education will be completed by 05/26/2025. Resident Council was held on 05/22/2025 to ensure all grievances were resolved. Beginning on 05/19/2025, all grievances will be discussed in our Morning standup meeting (Monday-Friday) to ensure the facility addresses and resolves all grievances in a timely manner.<br><br>On 05/26/2025 the Nursing Home Administrator (NHA) and/ or LSW will interview five residents per week to ensure there are no grievances unresolved for four-weeks and then monthly for three-months per facility Grievance Policy. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-585.<br><br>Compliance date: 06/02/2025 | |

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| M 500 | Continued From page 5<br><br>Resident #247 revealed she feels like it takes too long to be changed when she has had a bowel movement, and she has reported it at least three times and it is still not resolved.<br><br>During an interview on 5/15/25 at 8:20 AM, the Licensed Social Worker (LSW) revealed the resident has complained before about CNAs not answering the call light promptly and leaving her soiled for a long period. She revealed the resident has complained to me at least 3 times about this issue, and it could be more, and the Director of Nursing (DON) is aware of it as well. She confirmed she had not opened additional grievances each time the resident complained, but would report it to the DON, and if she were instructed to open a grievance, she would have done it.<br><br>An interview on 5/15/25 at 10:12 AM, Resident #247 revealed she had a good day yesterday until her sister brought her in from the outside activities. She revealed, "I saw my aide in the hallway, and I told him that I had a bowel movement and needed to be changed. He said ok, let me finish passing this ice and get my vital signs, and then I'll be right in there. My sister pushed me into my room, and I waited about an hour and a half. I have always reported it to the social worker (SW), and I called her yesterday and reported it to her again."<br><br>An interview on 5/15/25 at 10:30 AM, the DON revealed that she was aware of a grievance that the resident had on 3/24/25 that an aide had told her she was going to lunch and couldn't change her brief. She revealed we did address that grievance and thought we had a resolution and confirmed that she was unaware that it was still an ongoing concern and grievance for the | M 500 | | |

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| M 500 | Continued From page 6<br>resident.<br><br>During an interview on 5/15/25 at 10:45 AM, the Administrator (ADM) revealed she is the grievance officer, and she or the social worker usually opens a grievance form for any issue to be investigated. She confirmed that she was unaware of any other grievances voiced regarding Resident #247 not getting her care in a timely manner until yesterday. She revealed that a grievance form should have been opened if additional complaints were voiced to the social worker or any staff member. Then it would have been investigated correctly and followed through with a resolution and a follow-up.<br><br>A review of the "Admission Record" revealed the facility admitted Resident #247 on 2/3/25 with medical diagnoses that included Paranoid schizophrenia and Encephalopathy.<br><br>A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/8/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicated Resident #247 was cognitively intact. | M 500 | | |
| M 610 | 45.21.2 Activities of daily living<br><br>Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to:<br><br>1. Bath, dressing and grooming;<br><br>2. Transfer and ambulate; | M 610 | | 6/2/25 |

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| M 610 | Continued From page 7<br>3. Good nutrition, personal and oral hygiene; and<br><br>4. Toileting.<br><br>This Statute is not met as evidenced by:<br>Level II<br>Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care to maintain personal hygiene for two (2) of 20 sampled residents. Resident #63 and #75.<br><br>Findings include:<br><br>Record review of facility policy titled, "Resident Quality of Care", dated 8/24, revealed, "Each resident shall receive optimal care to attain and/or maintain the highest possible mental and physical functional status as determined by the comprehensive assessment and person-centered plan of care. Each resident's care is tailored to the functional status and needs they may have. ... At the time of the bath, all residents shall also receive, if applicable, nail care".<br><br>Record review of facility policy titled, "Nail Care", dated 1/24, revealed, "Purpose - to promote cleanliness, safety, and a neat appearance".<br><br>Resident #63<br><br>On 5/12/25 at 11:49 AM and again on 5/13/25 at 10:45 AM, an observation and interview of Resident #63 revealed that his fingernails were one (1) inch in length, jagged and had a brown substance underneath and the resident expressed a desire to have his nails trimmed.<br><br>During an interview of the observations on | M 610 | Resident #63s and resident #75s fingernails were cut, trimmed, and filed on 05/13/2025 by the Registered Nurse Supervisor (RN SPV).<br><br>Residents who require assistance with ADL for nail care have the potential to be affected by this deficient practice.<br><br>On 05/13/2025, a one-hundred precent audit was conducted by the Director of Nurses (DON) to ensure ADL nail care was provided to residents and nail care performed if needed. Beginning on 05/13/2025, the Licensed Nurses and Certified Nursing Assistants (CNAs) were educated by the Director of Nursing (DON) and/or Staff Development RN on ensuring ADL nail care is provided to residents and nail care performed if needed. Education will be completed by 05/26/2025. New hires will be educated upon hire on ensuring ADL nail care is provided to residents and nail care performed if needed by completing CNA Performance Evaluation Checklist.<br><br>Beginning on 05/19/2025, the DON and/or Nurse Supervisor will audit to ensure ADL nail care has been provided on five residents once a week for four-weeks, then five residents monthly for three-months and quarterly until substantial compliance is achieved. The Quality Assurance and Performance | |

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| M 610 | Continued From page 8<br><br>5/13/25 at 10:50 AM, Registered Nurse (RN) #1 confirmed Resident # 63's fingernails were very long and needed trimming. She noted that the resident could "scratch and make wounds" due to the length and condition of the nails.<br><br>During an interview on 5/14/25 at 1:46 PM with the Administrator, it was confirmed that a resident with long, jagged fingernails could potentially cause a skin tear.<br><br>Record review of the "Admission Record" indicated that the facility admitted Resident #63 on 2/10/2020 with a medical diagnosis that included Hemiplegia, Unspecified Affecting Right Dominant Side.<br><br>A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/4/25 revealed under section C, a Brief Interview for Mental Status "BIMS" summary score of 14 which indicated Resident #63 was cognitively intact.<br><br>Resident #75<br><br>During an interview and observation on 5/12/25 at 10:55 AM, Resident #75 revealed he wanted his fingernails trimmed. His fingernails were observed to be slightly long with a brown substance noted under nails.<br><br>During an interview and observation of Resident #75's nails on 5/13/25 at 11:10 AM, the Director of Nursing (DON) observed the long nails with the brown substance under the nails. The resident informed the DON that he preferred his nails to | M 610 | Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-677.<br><br>Compliance date: 06/02/2025 | |

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| M 610 | Continued From page 9<br>be shorter than they were. She acknowledged it was important to keep the nails clean and trimmed to protect the resident from skin concerns and infections. She confirmed the facility failed to maintain the resident's nails at a length he preferred and failed to keep the nails clean.<br><br>Record review of Resident #75's "Admission Record" revealed the facility admitted the resident on 8/30/23 with diagnoses that included Type 1 Diabetes Mellitus, Depression, and Hypertension.<br><br>Record review of Resident #75's MDS Section C dated 4/29/25, revealed a BIMS score of 13 which indicated the resident was intact cognitively. | M 610 | | |
| M 640 | 45.21.8 Accidents<br><br>Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies.<br><br>This Statute is not met as evidenced by:<br>Level III<br><br>Based on resident and staff interviews, record review, and facility policy review, the facility failed to protect a resident's safety and prevent an accident when staff failed to use a wheelchair lift safety belt to secure a resident's wheelchair on the lift gate during the lift procedure to place the resident into the back of the van. This resulted in the resident rolling backwards in the wheelchair | M 640 | On 3/14/2025, resident # 37 was assessed upon return by Director of Nursing (DON). Treatment initiated and care plan updated on 03/14/25. Certified Nurse Aide (C.N.A) #1 was suspended on 03/14/2025 and did not work past this date.<br><br>All residents who are transported in facility vehicle are at risk for this deficient | 6/2/25 |

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| M 640 | Continued From page 10<br>and flipping off the lift gate when it was lifted around four (4) feet high in the air and the resident hit backwards onto the concrete injuring her head and received a three (3) centimeter (cm) laceration to the back of her head. This was for one (1) of two (2) residents incidents reviewed. Resident #37<br><br>Findings Include:<br><br>Review of the facility policy titled "Policies for Company Owned Vehicle" with a revision date of 5/18 revealed under, "3. Seatbelts: The driver and all passengers in the company/facility owned vehicle must be safely restrained by buckled seat belts, wheelchair floor tie downs and wheelchair harness type seatbelts at all times the vehicle is in use. A qualified individual shall assist patients/residents/clients with seatbelts and wheelchair tie downs and belts, and is responsible for ensuring that all person(s) in the vehicle are safely seat belted ..."<br><br>An interview with Resident #37 on 5/12/25 at 2:15 PM revealed she goes to dialysis three times a week and requires the use of the facility transport van. She revealed that she had a recent fall from the van and indicated her wheelchair rolled off the wheelchair lift while loading onto the van.<br><br>Record review of Resident #37's "Witnessed Fall" dated 3/14/25 revealed, "This nurse was notified that resident rolled off lift and fell backwards while being loaded to be transported to dialysis. Resident lying on flat concrete. Resident able to sit up. Resident has laceration to back of head and complained of right side pain." Resident stated, "I fell backwards out of my chair and hit my head." Additionally, the facility started neurological checks, physician was contacted, | M 640 | practice.<br><br>All Licensed Class D facility drivers were in-serviced on facility policy Company Owned Vehicle Checklist and the Vehicle Lift Operations Proficiency Checklist which was completed on 03/14/2025 by DON. Beginning on 03/15/2025 DON conducted safety checks on facility van daily Monday-Friday for one-month to ensure safety belt was in use while operating the lift gate.<br><br>Beginning 05/22/2025, the DON and /or Charge Nurse will observe the loading of residents onto the van with the safety belt in use for residents who require the lift gate. Observations will be done Monday-Friday for four-weeks, once weekly for three-weeks and then once monthly until substantial compliance is achieved. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-689.<br><br>Compliance date: 06/02/2025 | |

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and the resident was transported to the hospital via ambulance.

Record review of Resident #37's "Progress Notes' dated 3/14/25 revealed, "Abrasion to the back of head is 3 cm by 3 cm - dry with no active bleeding."

Record review of the Emergency Department Records dated 3/14/25 revealed, Resident #37 had a computed Tomography scan (CT) of head and cervical spine and an X-ray of the right shoulder with no acute findings.

Record review of the written witness statement dated 3/14/25 revealed, "I was loading Resident #37 on the bus when the lift remote stopped working. I locked her wheelchair and went on the inside of the bus to manually pump the lift. I instructed her to keep the chair locked. Once I got the lift up, I told Resident #37 to wait for me to unlock her chair. She proceeded to unlock it and before I could catch her chair, she rolled off the lift and fell backwards" and was signed by Certified Nurse Aide (CNA) #1.

A telephone interview with CNA #1 on 5/14/25 at 8:18 AM revealed she was transporting Resident #37 to dialysis on the day she fell from the van. She explained that she was loading the resident onto the van by herself using the wheelchair lift, and the lift remote control messed up and would not rise. She stated she told the resident not to unlock her wheelchair brakes, and she went inside the back of the van to manually work the van lift. CNA #1 revealed the resident rolled back off the van lift and fell backward onto the pavement. She stated, "I was later informed by the Director of Nursing that I should have been using a strap (safety belt) when lifting the resident

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on the lift gate. CNA #1 revealed that she had never been told to use the strap, and confirmed she did not apply it that day. She additionally added, "I was told that we had to have 2 people with van transfers, but nobody was out there with me." She explained that she had been trained on the old transport bus and had only ridden on the newer bus and did not get training.

An interview with the Director of Nursing (DON) on 5/14/25 at 8:40 AM revealed staff called her to report Resident #37's fall from the van. She stated the resident was sent to the hospital, was evaluated, and had X-rays, which were all okay. She explained the fall was caused by the resident unlocking the wheelchair brakes, which caused her to roll back off the lift. The DON admitted that CNA #1 reported to her that she did not use the safety wheelchair strap during lift use and stated, "I believe she would have fallen off the lift regardless of using the strap, but I know the belt is there for a reason." She confirmed the belt should have been used. She stated, "After the fall, I started retraining and called corporate and suspended CNA #1." She explained that CNA #1 resigned after the incident and never returned to work. The DON revealed the aide was new to the transport position and had been working for less than 2 weeks when the event occurred. She revealed the aide had training and checkoffs before driving the van and knew the safety strap was required. She explained the facility only used one staff member for transport unless the resident had dementia (poor cognition) or was an amputee and stated, "Really, it's a case-by-case basis" on using one versus two staff members."

An interview with the Administrator (ADM) on 5/14/25 at 9:10 AM revealed CNA #1 hired in and worked for a while and then decided to become

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the backup van driver. She confirmed the aide trained for more than 2 weeks and had check offs prior to starting the position. She acknowledged she reviewed and signed off on the incident report for Resident #37's fall and explained that she was off during that time and the DON handled the investigation. The ADM revealed the aide had no prior write ups or concerns with the care she provided to the residents.

Record review of the "Employee Warning Report" dated 3/14/25 revealed, "Elder rolled off the back of the van lift- elder unlocked w/c (wheelchair). It rolled back off lift. Lift safety belt was not latched." Certified Nurse Aide #1 was suspended and signed acknowledgment of receipt.

Record review of the "Company Owned Vehicle Driver Inservice Checklist" dated 2/28/25 revealed under, "Patient/Passenger Safety & (and) Special Equipment: The proper and safe operation of the wheelchair lift" was initialed by Certified Nurse Aide #1 as completed. Further review revealed she signed the "Vehicle Lift Operations Proficiency Checklist" dated 2/28/25.

On 5/15/25 at 8:11 AM, during a follow up telephone interview with CNA #1, she revealed she did train with CNA #2 and CNA #3 and stated neither told her nor showed her to use the safety belt with the wheelchair lift. She confirmed she signed the training record and stated, "That's my fault; I should have paid more attention when I signed it." CNA #1 confirmed she knew the strap was there and it would make sense to use it for the residents' safety and acknowledge this would have prevented the fall.

An interview with CNA #2 on 5/15/25 at 8:24 AM revealed that she trained CNA #1 on the newer

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| M 640 | Continued From page 14<br>van for a total of five days. She stated, "I explained to her about the safety belt and how to use it."<br><br>An interview with CNA #3 on 5/15/25 at 9:05 AM revealed that she trained CNA #1 on the transport van and fully explained to her that she had to use the safety belt on the wheelchair lift. She revealed CNA #1 had more than 2 weeks of training on the safety of transportation and using seat belts and safety straps.<br><br>An interview with the Administrator with the DON in attendance on 5/15/25 at 9:21 AM confirmed the investigation into Resident #37's fall revealed CNA #1 did not use the safety belt during the van lift process, which resulted in the resident's fall backwards in her wheelchair from the lift gate which was lifted around four feet high, to the concrete below. The DON stated the aide admitted she did not use the strap and acknowledged she was trained to utilize the wheelchair strap when lifting residents on the lift gate.<br><br>A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/02/25, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 14, indicating that Resident #37 was cognitively intact.<br><br>A record review of the "Admission Record" revealed that the facility admitted Resident #37 on 11/15/16 with a medical diagnosis that included End Stage Renal Disease. | M 640 | | |
| M 815 | 45.29.1 Safe Food Handling Procedures<br><br>Safe Food Handling Procedures. Food shall be | M 815 | | 6/2/25 |

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| M 815 | Continued From page 15<br>prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations.<br><br>This Statute is not met as evidenced by:<br>Level II Widespread<br><br>Based on observations, interviews, record reviews, and facility policy review, the facility failed to label and store food properly and maintain the kitchen and the equipment in a clean and sanitary condition for two (2) of three (3) kitchen tours.<br><br>Findings included:<br><br>Review of the facility's policy titled, "Food Storage Labeling," with revised date 5/18 revealed, "Policy: The facility will ensure the safety and quality of food by following good food storage labeling procedures ..."<br><br>Review of the facility's policy titled, "Cleaning Schedule," with revised date 5/18 revealed, " ...Procedure: ...All equipment and work areas are cleaned after each use, or, on a routine basis ... A cleaning schedule is established by the Director of Food and Nutrition Services ...The Director of Food and Nutrition Services checks routinely to see that the task is completed according to standards ..."<br><br>During the initial kitchen tour with the Dietary Manager (DM) on 5/12/25 at 10:24 AM several observations were made regarding food storage practices. In produce refrigerator number one (1), several items, including mashed potatoes, spam, applesauce, orange juice, apple juice, cranberry juice, and a sliced onion were present without | M 815 | On 05/12/2025, the Dietary Manger (DM) discarded all items in all refrigerators and dry food storage that were not labeled per Centers for Medicare and Medicaid Services (CMS) guidelines. On 05/14/2025 the roll-up food service window and the steam table were cleaned by the DM to ensure sanitary conditions per CMS guidelines. Dietary staff responsible for the proper labeling/dating of food items were disciplined on 5/12/25 by the DM.<br><br>All residents have the potential to be affected by this deficient practice.<br><br>On 05/12/2025 the DM in-serviced all kitchen staff on facility Labeling and Storage Policy. On 05/14/2025 the DM in-serviced all kitchen staff on the facility policy on Cleaning Schedule Procedure. On 05/14/2025 DM and/or Production Supervisor (PS) will inspect the rollup door weekly and steam table daily per cleaning schedules to ensure sanitary conditions per CMS guidelines. All education will be completed by 05/26/2025.<br><br>On 05/26/2025 DM and/or PS will audit cleaning schedule checklist and labeling/dating checklist to ensure compliance per facility policy on Cleaning Schedule and Food Storage Labeling. The audit will be completed daily for | |

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| M 815 | Continued From page 16<br><br>dates indicating when they were opened or when they expired. Similarly, in produce refrigerator number two (2), several items, such as pimento cheese, sweet and sour sauce, BBQ sauce, mayonnaise, and potato salad, were also opened and undated. The dry storage room revealed more of the same concerning practices, with items like creamy peanut butter, powdered sugar, brown sugar, key lime sauce, teriyaki sauce, Worcestershire sauce, and grits lacking appropriate dating with opened containers.<br><br>During an interview on 5/12/25 at 10:50 AM with the DM, he confirmed that no open food items should be stored without an open date. He further emphasized that this practice is unacceptable as it could lead to food-borne illnesses.<br><br>During an interview on 5/12/25 at 11:15 AM with the Administrator, she confirmed that the facility policy requires that open food items be labeled with an open date, underscoring the importance of adherence to safety protocols.<br><br>During an observation and interview on 5/14/25 at 11:05 AM with the Production Supervisor, she confirmed that the roll-up food service window located directly above the steam table was heavily covered across the top and down the sides with large accumulations of dust and grease. Additionally, other dirt and dust particles were in each individual slat. The steam tables also had old grease drippings on the bottom shelf. When questioned about the responsibility for cleaning the roll-up service window, she expressed uncertainty, stating, "I'm not sure who is responsible for cleaning the roll-up service window, whether it's dietary or maintenance."<br><br>During an interview on 5/14/25 at 11:08 AM with | M 815 | four-weeks and monthly for three-months. The Nursing Home Administrator (NHA) will audit the cleaning schedule checklist and labeling/dating checklist weekly for four-weeks and monthly for three-months. The Quality Assurance and Performance Improvement (QAPI) will convene on 05/29/2025 to discuss further recommendations as needed and will meet once a month for three-months until substantial compliance is achieved. The QAPI Committee will revise the corrective action plan as needed until substantial compliance is achieved with F-812.<br><br>Compliance date: 06/02/2025 | |

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| M 815 | Continued From page 17<br>the DM, he revealed that both he and the Maintenance Supervisor were responsible for cleaning the roll-up service window. However, he acknowledged that it had not been cleaned in quite some time and was in a dirty state, indicating a need for immediate attention. He further expressed concern that the accumulation of dirt and dust and that it could fall into the food as the roll-up window was opened for service. Additionally, he confirmed that this situation could cause the food to become contaminated and that proper cleaning protocols should be enforced to ensure the safety of the residents. | M 815 | | |