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	04AC	A. BUILDING: _____ B. WING _____	09/15/2022

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey from 09/12/22 to 09/15/22. The SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M190, M500, M610, M640 and M815. At the time of the survey the census was 104 and the facility is licensed for 120 beds.	M 000		
M 190	45.2.33 Restraint Restraint. The term "restraint" shall include any means, physical or chemical, which is intentionally used to restrict the freedom of movement of a person. This Statute is not met as evidenced by: Level III Based on observations, staff, resident and resident representative's interviews, record review and facility policy review the facility failed to ensure a resident was free from physical restraints as evidenced by a full side rail used without an assessment, medical symptom, or ongoing evaluation for one (1) of seven (7) residents reviewed with full side rails. Resident # 16 Findings include: Record review revealed the facility policy titled, "Restraints" with a revision date of 09/18 revealed, "It is the philosophy of this facility that a resident has the right to be free from any physical or chemical restraints not required to treat the resident's medical symptoms. Restraints may not be used for the convenience of the nursing staff or as punishment to the resident". This policy	M 190	Plan of Correction *All side rails were removed from six beds. Resident #16 bed was removed and replaced with an electric bed with half rails on 9/12/22 by the Housekeeping Supervisor. Resident #16 device assessment and consent were updated on 9/12/22 by the Assessment Nurse. Resident #16 Physician and Resident Representative were notified of change of bed on 9/12/22 by Licensed Practical Nurse. Seven residents were identified with full side rails on their beds having the potential to be affected by this deficient practice. Six of the seven residents with full side rails were not in use and were removed from the beds by 9/30/22 by the Housekeeping Supervisor and one resident was assessed by the Assessment Nurse on 9/28/22 for the full side rails and uses these for bed mobility and	10/31/22

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M 190	Continued From page 1 review revealed under "Physician Restraint Definition ...The use of a restraint will require a determination of need to be completed by a licensed nurse, a signed consent and a physicians order prior to applying restraints". An observation on 9/12/22 at 10:20 AM, revealed Resident #16 sitting in the hall in her wheelchair with multiple dried blood areas in her hair and on the front of her gown. This observation revealed that Resident # 16 had a raised purple area on the top left side of her forehead and a brace on her left wrist. During this observation Registered Nurse (RN) # 1 and a maintenance staff member were removing Resident # 16's manual crank bed with full side rails and replacing it with an electric bed with half side rails. Record review of Resident # 16's Physician Orders List revealed an order dated 3/15/22, "SIDERAIL (FULL) X 1 FOR BEDMOBILITY". Record review of Resident # 16's Device/Physical Restraint Consent, undated, revealed it was not signed by the resident or resident representative. Record review of the medical record revealed there was no Side Rail/Restraint Assessment's for Resident # 16 An interview on 9/12/22 at 10:25 AM, with Certified Nurse Assistant (CNA) # 5 revealed that Resident # 16 had fell out of the bed early this morning before she got to work. She revealed she is not sure what happened or the extent of her injuries. An attempted interview on 9/12/22 at 10:28 AM, with Resident # 16 revealed the resident is soft spoken but able to answer simple yes or no	M 190	communication which is not a restraint as the resident does not ambulate or attempt to get out of bed *Seven residents with long bed rails have the potential to be affected by this deficient practice. * Beginning 9/21/22 Nursing staff was in-serviced by the Staff Development Nurse on the "Restraint" policy revised 9/2018, with no interval changes, to include side rail usage and completing device assessments with any changes in bed rails to include properly assessing residents for side rail usage and will continue until all nurses are in-serviced. *The Quality Assurance Committee will address concerns identified from side rails checks and evaluate the audit forms completed by the Director of Nursing, Charge Nurse, Assessment Nurse, or Nurse Case Manager monthly for three months and make any recommendations or changes needed until resolved on 10/14/22. Beginning 9/12/22, the Director of Nursing, Charge Nurse, Assessment Nurse or Nurse Case Manager will check at least six resident side rails to ensure the physician order and device assessment match the side rail present on resident's bed and appropriately assessed and record on the medical record audit form weekly for three weeks and monthly for three months and maintained by the Administrator. The facility plans to monitor its performance by inspecting beds received in the facility by Housekeeping Supervisor prior to resident admission or resident room transfer.	

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questions. When inquired what had caused her injuries, Resident # 16 did not respond.

An interview on 9/12/22 at 2:30 PM, with Licensed Practical Nurse (LPN) # 2 revealed Resident # 16 fell out of the bed around 4:30 AM, was sent to the Emergency Room (ER) and returned with a broken wrist and bruising.

An interview on 9/13/22 at 3:17 PM, with Resident # 16 revealed the resident was able to answer simple yes or no questions. When ask if she remembered what happened when she fell, Resident # 16 mumbled something that I could not understand.

An observation on 9/14/22 at 8:30 AM, revealed Resident # 16 lying in bed with dark purple bruising to her right shoulder that continued down her arm to her elbow, dark purple bruising to her left arm from her elbow that continued through her left hand, dark purple bruising noted to the top left side of the resident's forehead with a scar across the bruising that is approximately two (2) inches long with dried blood. This observation revealed the resident was wearing a wrist brace to her left arm.

An interview on 9/14/22 at 8:32 AM, with Resident # 16's Daughter in Law, revealed they were notified that the resident had fallen out of bed and was sent to the ER. She revealed the resident has always been bad to fall, she has fallen here before and at home. She revealed the other bed had full rails that went to the foot of her bed, and we liked that and this one does not. She revealed it seems like she should have full rails.

An interview on 9/14/22 at 10:30 AM, with LPN-Infection Control Nurse revealed she was

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M 190	Continued From page 3 Resident # 16's nurse on the night of her fall on 9/12/22. She revealed she was called to the room by CNA # 10 and when she got to the room the resident was lying on her right side in the floor with her head on the end by the head of the bed, legs straight out and arms crossed in front of her. She revealed the resident was holding her left wrist with her right hand. She revealed the resident had a laceration to her head that was bleeding. She confirmed the left side of the resident's bed was against the wall and a full side rail was up on the right. She revealed the CNA told her that they heard a loud noise like a boom as if something had fallen and that is when CNA # 10 found her around 3:30 AM. She revealed she does not know why the full side rail was ordered or for how long, but the resident was still able to get her legs over the rail because it was short in height. She revealed that the preventative measures that were in place prior to the 9/12/22 fall included, checked, and turned every two (2) hours and the nurse usually does rounds in between those 2 hours, and a full side rail. An attempted interview on 9/14/22 at 11:01 AM, with CNA # 10 revealed no answer and no voice mail. An interview on 9/14/22 at 2:28 PM, with CNA # 5 revealed that Resident # 16's care included that she have a full side rail up X (times) one (1) and the other side of her bed was against the wall. She revealed that when the resident was in the bed her full side rail stayed up all the time on the side that was not against the wall and the resident could not let her bed rails down on her own. An interview on 9/14/22 at 2:42 PM, with LPN # 2 revealed that Resident # 16's care included repositioning every 2 hours and a full side rail.	M 190		

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She revealed that the full side rail was used for repositioning, and she could not let them down herself.

An interview on 9/15/22 at 9:45 AM, with the Director of Nursing (DON) revealed that the resident's left side of her bed was against the wall and the right side had a full rail when the fall occurred on 9/12/22. She revealed she is not sure why the full side rail X 1 was ordered on 3/15/22. She revealed she does not like the full rail beds and will argue with families about having it if they request it, because they just don't understand what it can cause. She revealed that the side rail did not prevent her from getting out of the bed but can understand how the full side rail could be considered a restraint and could increase the severity of an injury when the resident has to climb over it to get out of the bed.

An attempted phone interview on 9/15/22 at 12:42 PM, with Doctor (Dr.) # 1 revealed no answer for his office.

Record review and interview on 9/15/22 at 1:15 PM, with LPN-Medical Records Nurse revealed that RN-Minimum Data Set (MDS) nurse wrote the order for the full side rail on 3/15/22 and Dr. # 1 signed it in 4/2022.

An interview on 9/15/22 at 1:20 PM, with the Administrator revealed she did not know the resident had a bed with a full rail and if she had of known then the resident would not have had it, because we do not use those.

An interview on 9/15/22 at 1:25 PM, with RN-MDS nurse revealed she completed Resident # 16's quarterly assessment on 3/15/22 and when she walked in the resident's room, the resident

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M 190	Continued From page 5 had a full side rail up. RN-MDS revealed that she wrote the order for the full side rail at that time, so that it would match what the resident physically had, and her MDS assessment would be correct. RN-MDS revealed she did not report to the DON or anyone else that the resident had a full side rail, because they had several of those beds in the facility at the time and she assumed that was why she had it. She revealed she is not aware of how long the resident had a full side rail prior to her finding it on her 3/15/22 MDS assessment. An interview on 9/15/22 at 3:15 PM, with Doctor (Dr) # 1 revealed he does not recall without doing a chart review why he ordered a full side rail X 1 on Resident # 16. Dr. # 1 revealed he recalls that the resident had dementia, had some falls in the past and had been trying to get out of bed. Record review of Resident # 16's Face Sheet revealed the resident was admitted to the facility on 04/06/21 with medical diagnoses that included Primary generalized osteoarthritis, Spondylosis without myelopathy or radiculopathy, Alzheimer's disease, Unspecified dementia without behavioral disturbance. Record review of Resident # 16's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/22 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 09 which indicates Resident #16 has moderate cognitive impairment.	M 190		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility:	M 500		10/31/22

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M 500	Continued From page 6 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; 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; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his 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; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other	M 500		

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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;

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;

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;

7. is free from mental and physical abuse;
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

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M 500	Continued From page 8 of the emergency application of the restraint; 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; 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; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other 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); 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); 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	M 500		

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M 500	Continued From page 9 by his physician or nurse practitioner/physician assistant in his medical record); 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 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. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, and record review, the facility failed to honor the residents' rights to self-determination with their choice to smoke according to the facility's smoking schedule, for two (2) of five (5) smokers interviewed. Resident #58 and #80 Findings include: Record review revealed there was no facility policy related to resident smoke breaks and the facility's responsibility to ensure residents are taken out for a smoke break. The Administrator (ADM) provided documentation on the facility letterhead that noted, "We do not currently have a policy in place for transporting residents to the smoking area or one for smoking times available to the residents." An interview on 9/12/22 at 11:24 AM, with	M 500	Plan of Correction *The smoking schedule was revised to include additional indirect staff Monday through Friday on September 14,2022 by the Administrator to provide more compliance with scheduling and Saturday and Sunday smoke breaks were revised 10-3-22 to allow direct care staff to complete designated responsibilities. Resident #58 and #80 had no adverse effects from the deficient practice. * Fifteen (15) residents who smoke were identified to have the potential to be affected by the same deficient practice. The fifteen residents identified have had no adverse effects noted from this deficient practice. *An in-service was held on 9-21-22, and staff were in-serviced by the Staff Development Nurse on "Resident Rights" policy revised 11/17. Beginning 10/4/22, staff in-serviced by the staff Development	

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M 500	Continued From page 10 Resident #58 revealed she was not getting to go out and smoke on all the smoke breaks on the weekend and the smoke breaks through the week happened late most times. Resident #58 revealed it was very important that she got to go out and smoke. Resident #58 revealed she had spoken to the Administrator about being able to smoke on the weekends. An interview on 9/12/22 at 11:55 AM, with Resident #80 revealed he had a problem with the smoke breaks because he never gets to smoke on time through the week and does not get all his smoke breaks on the weekend. Resident #80 revealed he had talked to the ADM about getting someone to start back taking them out on time to smoke. Resident #80 revealed it just got bad lately not being able to get our smoke breaks. An observation and interview on 9/12/22 at 4:50 PM, with Resident #80 revealed the smoking break was scheduled for 4:30 PM, the smoke break was late again and no staff was able to take the smokers out. Resident #80 revealed the smokers must stay in the hallway waiting for someone to show up and take them out to avoid missing the smoke break. Resident #80 revealed the Director of Nursing (DON) told the smokers she will find someone to take the smokers out. An interview on 9/12/22 at 4:55 PM, with the DON, revealed she was trying to find a staff member to take the smoking residents out, that she was not aware of the location of the person that was scheduled to take the smokers out at the 4:30 PM scheduled time. An interview 9/13/22 at 9:30 AM, with Resident #58 revealed she had to go to get the ADM to take the smoking residents out for a smoke break	M 500	Nurse on "Smoking Policies and Regulations" policy revised 9/22 and the revised smoking schedule dated 9-14-22 and will continue until all staff are in-serviced. Resident Council meeting was held on 10-4-22 with smoking schedule discussed with residents by Activities Director and then discussed again with smokers on 10-4-22 by the Administrator to include revised schedule. as needed. *Beginning 9/19/22, the smoking schedule will be monitored for scheduled times that residents were assisted to smoke versus actual times residents are assisted to smoke by the Administrator, Charge Nurse, Housekeeping Supervisor or Maintenance Director weekly for three weeks and monthly for three months with findings documented on the smoking schedule sheet for compliance. *The Quality Assurance Committee verbally reviewed the smoking policy with revision date 9/22 with no further changes suggested. The Quality Assurance Committee will address concerns identified from the monitoring by the Administrator, Charge Nurse, Housekeeping Supervisor or Maintenance Director monthly for three months and make any recommendations or changes needed until resolved on 10/14/22.	

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M 500	Continued From page 11 after 5:00 PM yesterday (9/12/22). An interview on 9/14/22 at 1:55 PM, with the Licensed Practical Nurse, (LPN) #4, revealed there was difficulty getting staff members to take the smoking residents out for a smoke break at the scheduled times, and the smoke breaks are often completed late. LPN #4 revealed a smoking schedule posted at the nurse's station had different department disciplines designated to take smokers out, and with an assigned staff member that was to assist with the smoking residents to get to and from the smoking area. LPN #4 noted the schedule was not followed the way it was typed because there was a Floor Tech previously employed by the facility that took the residents on almost all the smoke breaks, Monday - Friday. LPN #4 revealed the Floor Tech's supervisor would be the back-up person if the Floor Tech was not available for a smoke breaks and the nursing staff only had to do the 7:00 PM smoke break Monday - Friday. LPN #4 noted the Floor Tech resigned 2 weeks ago and his supervisor had been too busy to come and help with the smoke breaks. LPN #4 revealed she did not know who was responsible to ensure the schedule of staff members assigned to help with the smoke breaks was followed and the nurses did not assign the task of taking the smoking residents out on breaks to the Certified Nursing Assistants (CNAs) when daily resident assignments were done. An interview on 9/14/22 at 2:10 PM, with Registered Nurse (RN)#1, revealed it was difficult to get residents out to smoke on the weekends, and tried to help as much as she could to get them to as many breaks as possible. RN #1 revealed usually she only worked to 1:00 PM on Saturdays and Sundays and it was difficult to get	M 500		

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staff to assist with the resident smoke breaks, and residents did miss some of the weekend smoke breaks.

An interview on 9/14/22 at 2:16 PM, with LPN #5, revealed the residents do not get out timely to smoke breaks through the week, and she assisted to get them out when she could.

An interview on 9/14/22 at 02:40 PM, with the ADM revealed she ensured that the residents went out for every smoke break when she was in the building, but it was the responsibility of the charge nurse to ensure the residents smoked on the weekends. The ADM confirmed she took the smokers out on Monday, 9/12/22, confirmed that the break was late, and confirmed the smoke breaks are often completed late. The ADM revealed there was a schedule posted for employees to take the smokers out, the staff was aware of the schedule. The ADM did not identify a responsible staff member that ensured the schedule was followed, could not recall who completed the schedule and confirmed no changes had been made to the schedule since the Floor Tech left 2 weeks ago. The ADM revealed if Resident #80 and Resident #58 felt that their choice to go out and smoke at the scheduled times was not being honored, then the facility was not honoring their choices and their Resident Rights.

An interview 9/14/22 at 04:42 PM, with CNA #7, revealed the CNAs do not know when they are on the schedule to take smokers out. She noted they had never followed a schedule to take smokers out before and the Floor Tech did all the smoke breaks.

An interview on 9/15/22 at 10:40 AM, with the

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Housekeeping Supervisor, revealed he helped to get the resident's out to smoke breaks. The Housekeeping Supervisor revealed he was only scheduled for Tuesdays to take the residents out to smoke, remembers his assigned time, and would fill in when he could for the area that was assigned to the Floor Tech.

An interview on 9/15/22 at 11:20 AM, with CNA #6, revealed the CNAs are used as back-up for taking the smoking residents out. CNA #6 revealed the CNAs are on the schedule to take the smoking residents out but are not responsible to do more than assist in getting residents in and out of the smoking area.

An interview on 9/15/22 at 11:23 AM, with CNA #8 revealed she would help get them to and from the smoking area but cannot be responsible to stay outside with the smokers. CNA #8 revealed she was made aware of the schedule for the staff members to take residents out for a smoke break from other staff members, but no specific person told them to follow the schedule.

An interview on 9/15/22 at 11:26 AM, with CNA #9, revealed she knows the smoking residents have a hard time getting out for smoke breaks, but the 7-3 shift CNAs have all the work to do in the mornings and cannot get to take residents outside to smoke. CNA #9 revealed the staff schedule for the smoke breaks does not apply to the 7-3 shift and the 7-3 shift CNAs are only to assist as they can.

Record review of the "Smoking Schedule" revealed the staff members assigned to take the smoking residents out for the scheduled smoke breaks and "In the event the person who is supposed to smoke is unable to do so, they are

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M 500	Continued From page 14 responsible for finding a replacement." The "Smoking Scheduled" also revealed the schedule was for the entire week, listed all the designated smoking times, listed a primary staff member responsible for the task of monitoring the smokers during the breaks, and a staff member to assist to get the smoking residents to and from the smoking area. The "Smoking Schedule" reflected the Housekeeping Supervisor was scheduled primary for Tuesdays at 1:30 PM and the Floor Tech was scheduled primary for Mondays, Wednesdays, and Fridays at 9:30 AM. It noted the CNAs were scheduled primary daily at 4:30 PM and 7:30 PM, but a CNA was scheduled to assist the primary on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday for all smoke breaks. The "Smoking Schedule" did not reveal the date it was initiated. Record review of the "Smoker Worksheet" revealed Resident #58 and Resident #80 are listed as smokers and the facility's daily smoking times are 9:00 AM, 11:00 AM, 1:30 PM, 4:30 PM, and 7:00 PM. Record review of the Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 5/10/22 for Resident #58, revealed Resident #58 has a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #58 is cognitively intact. Record review of a Quarterly MDS Assessment, with an ARD of 8/4/22 for Resident #80, revealed Resident #80 has a BIMS score of 09, indicating Resident #80 is moderately cognitively impaired.	M 500		
M 610	45.21.2 Activities of daily living	M 610		10/31/22

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M 610	Continued From page 15 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: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility policy review the facility failed to provide nail care for a resident dependent on staff for Activities of Daily Living (ADL's) as evidenced by a brown substance under the resident's nails for one (1) of five (5) residents reviewed for ADL's. Resident # 56 Findings Include. Review of the facility policy titled, "Nail Care" with a revision date of 10/17 revealed under "Purpose...To promote cleanliness, safety and a neat appearance..." An observation on 09/12/22 at 11:00 AM, revealed Resident # 56 lying in bed, fingernails long with a brown substance under every fingernail. An observation on 09/13/22 at 08:59 AM, revealed Resident # 56 had a brown substance under all of her fingernails. An observation on 9/13/22 at 12:08 PM, revealed	M 610	Plan of Correction *On 9-13-22, resident #56 fingernails were cleaned and trimmed by Licensed Practical Nurse with no adverse signs or symptoms. All other resident's fingernails were checked for the need to be cleaned or trimmed by Licensed Practical Nurse. Certified Nursing Assistants were in-serviced on providing nail care during Activities of Daily Living care by Staff Development Nurse on 09/21/22. Fingernails are trimmed by nursing staff as needed to ensure weekly performance compliance. *All residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. No other residents were identified as affected by this deficient practice. *Beginning on 9-23-22, an in-service was conducted with nursing staff by the Staff Development Nurse on the policy/procedure titled "Nail Care" revised 10/17, which included ensuring residents nails are cleaned and trimmed. Beginning	

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M 610	Continued From page 16 Resident # 56 had a brown substance under all of her fingernails. An observation on 9/13/22 at 2:00 PM, revealed Resident # 56's fingernail's had a brown substance under every nail. An observation and interview on 9/13/22 at 4:10 PM, with the Director of Nurses (DON) confirmed the resident's nails were dirty and needed to be cleaned and it was the responsibility of the nurse to file and trim her nails, but it was the responsibility of the CNA to clean this resident's nails and that would be documented on the Electronic Treatment Administration Record (ETAR). An interview on 9/13/22 at 2:30 PM, with Certified Nurse Assistant (CNA) # 1 revealed that the CNA's are responsible for providing baths to the residents. CNA #1 revealed that when the residents get a bath that includes having their hair washed and combed, nails cleaned and shaved if needed. CNA #1 revealed that if the resident is a diabetic then the nurse does the resident's nail trimming, otherwise the CNA can do it. An interview on 9/13/22 at 3:02 PM, with Licensed Practical Nurse (LPN) # 1 revealed it is the responsibility of the CNA to provide the residents with a bath of some sort every day. LPN #1 revealed it is the responsibility of the CNAs to do nail care and shaving along with the resident's bath unless the resident is a diabetic and then the nurse does it. An interview and observation on 9/13/22 at 3:20 PM, with CNA # 3 confirmed the resident's nails had a brown substance under every nail and it had an odor. CNA #3 confirmed that the	M 610	9/19/22, the Director of Nursing, Charge Nurse, Treatment Nurse, or Staff Development will monitor 10 resident's fingernails for cleanliness and record findings on the medical record audit form weekly for three weeks and monthly for three months and maintained by the Administrator. The Quality Assurance Committee will address concerns identified from checks on 10/14/22 and evaluate the monitoring completed by the Director of Nursing, Charge Nurse, Treatment Nurse, or Staff Development Nurse monthly for three months and make any recommendations or changes needed until resolved.	

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M 610	Continued From page 17	M 610		

resident's nails needed to be cleaned and she was not sure what that brown substance was.

An interview on 9/14/22 at 8:35 AM, with CNA # 4 revealed the CNAs are responsible for cleaning the resident's nails and confirmed she has seen brown stuff under the resident's nails before.

An interview on 9/15/22 at 11:44 AM, with the DON confirmed the brown substance under Resident
56's nails could have caused the resident to have an upset stomach and diarrhea.

An interview on 9/15/22 at 1:22 PM, with the Administrator revealed that the brown substance under Resident # 56's nails could have made her sick if she put her hands in her mouth.

Record review of Resident # 56's Face Sheet revealed the resident was admitted to the facility on 10/19/21 with diagnoses that included Acute embolism and thrombosis of unspecified vein, Personal history of transient ischemic attack (TIA), Cerebral infarction without residual deficits and Ileus.

Record review of "Diabetic Nail Care Assignments" revealed that the 7 AM-3 PM LPN was responsible for diabetic fingernail care.

Record review of Resident # 56's ETAR revealed that the resident had no nail care performed by the nurse for the month of August or September 2022.

Record review of Resident # 56's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/14/22 revealed in Section C a Brief Interview of Mental Status (BIMS) of 03, which

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M 610	Continued From page 18 indicates the resident is severely cognitively impaired.	M 610		
M 640	45.21.8 Accidents 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. This Statute is not met as evidenced by: Level III Based on observations, staff, resident and resident representative's interviews, record review and facility policy review the facility failed to ensure a resident was free from accident hazards as evidenced by the facility's failure to identify a full side rail as a hazard. Resident #16 sustained a fall from the bed and a fractured wrist. Resident #16 was one (1) of two (2) residents reviewed for falls. Findings include Record review of the facility policy titled, "Accident Prevention" with a revision date of 11/17 revealed, "Each resident shall receive adequate supervision and assistive devices to prevent accidents". Review of the facility policy with a revision date of 09/18 titled, "Fall Prevention and Management Program" revealed under "Prevention...The staff will identify and implement interventions related to a resident's specific risk factors to try to prevent falls from occurring..."	M 640	Plan of Correction *Resident #16 bed with long side rails was removed and replaced with an electric bed with half rails on 9/12/22 by the Housekeeping Supervisor. Resident #16 device assessment and consent were updated on 9/12/22 by the Assessment Nurse. Resident #16 Physician and Resident Representative were notified of the incident involving fall on 9/12/22 by Staff Development Nurse. Seven residents were identified with full side rails on their beds having the potential to be affected by this deficient practice. Six of the seven residents with full side rails were not in use and were removed from the beds by 9/30/22 by the Housekeeping Supervisor. One resident was assessed by the Assessment Nurse on 9/28/22 for the full side rails and uses these for bed mobility and communication. This is not a restraint as the resident does not ambulate or attempt to get out of the bed. *Seven residents were identified with full side rails on their beds having the	10/31/22

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M 640	Continued From page 19 Observation on 09/12/22 at 10:20 AM, revealed Resident # 16 was sitting in the hall in her wheelchair with multiple dried blood areas in her hair and on the front of her gown. This observation revealed that Resident # 16 had a raised purple area on the top left side of her forehead and a brace on her left wrist. During this observation Registered Nurse (RN) # 1 and a maintenance staff member were removing Resident # 16's manual crank bed with full side rails and replacing it with an electric bed with half side rails. During an interview on 9/12/22 at 10:25 AM, with Certified Nurse Assistant (CNA) # 5 revealed that Resident # 16 fell out of the bed early this morning. She revealed she is not sure what happened or the extent of her injuries. In an interview on 9/12/22 at 10:28 AM, with Resident # 16 revealed the resident is soft spoken but able to answer simple yes or no questions. When inquired what had caused her injuries, Resident # 16 did not respond. Record review of the Resident Incident Report revealed that Resident # 16 had an unwitnessed fall on 9/12/22 at 3:29 AM and was discovered on the floor on her right side next to her bed with her head against bedside nightstand and blood noted to head and floor with a laceration noted to her head, a bruise to her right lower leg, a bruise to her right elbow and a bruise to her right arm. This review revealed the resident was sent to the ER. Record review from Resident incident follow up dated 9/12/22 revealed CNA # 10's last round on Resident # 16 was at 3:10 AM and at that time the resident's full side rail was up and she was	M 640	potential to be affected by this deficient practice. Six of the seven residents with full side rails were not in use and were removed from the beds by 9/30/22 by the Housekeeping Supervisor. One resident was assessed by the Assessment Nurse on 9/28/22 for the full side rails and uses these for bed mobility. Resident does not speak and when in need of assistance, he shakes the side rails to alert staff of needs. This is not a restraint as the resident does not ambulate or attempt to get out of the bed. *Beginning 9/21/22, Nurses were in-serviced by the Staff Development Nurse on the "Restraint" policy revised 9/18 to include side rail usage and completing device assessments with any changes in bed rails to include properly assessing residents for side rail usage. Beginning 9/21/22, Nurses were in-serviced by the Staff Development Nurse on "Accident Prevention" policy revised 11/17 and "Fall Prevention Management Program" revised 9/18 to include the use of assistive devices to prevent accidents and will continue until all nurses are in-serviced. Beginning 9/19/22, the Director of Nursing, Charge Nurse, Assessment Nurse, Staff Development Nurse, or Nurse Case Manager will check at least 10 residents for assistive devices in use to ensure the device in use is appropriate to prevent falls from occurring on residents and appropriately assessed and record on the medical record audit form weekly for three weeks and monthly for three months and maintained by the Administrator. *Prior to admission or room transfers,	

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M 640	Continued From page 20 resting. Licensed Practical Nurse (LPN) # 2 reported during an interview on 9/12/22 at 2:30 PM, that Resident # 16 fell out of the bed around 4:30 AM, was sent to the Emergency Room (ER) and returned with a broken wrist and bruising. On 9/13/22 at 3:17 PM, during an interview with Resident # 16 revealed that the resident was able to answer simple yes or no questions. When asked if she remembered what happened when she fell, Resident # 16 mumbled something that the SA could not understand. On 9/14/22 at 8:30 AM, during an observation revealed Resident # 16 lying in bed with dark purple bruising to her right shoulder and it continued down her arm to her elbow, dark purple bruising to her left arm from her elbow that continued through her left hand, dark purple bruising noted to the top left side of the resident's forehead with a scar across the bruising that is approximately two (2) inches long with dried blood. This observation revealed the resident was wearing a wrist brace to her left arm. During an interview on 9/14/22 at 8:32 AM, with Resident # 16's daughter-in-law, revealed they were notified that the resident fell out of bed, was sent to the ER and had broken her wrist. She revealed the resident has always been bad to fall, she has fallen here before and at home. She revealed the other bed had full rails that went to the foot of her bed, and we liked that and this one does not. She revealed it seems like she should have full rails. In an interview with LPN-Infection Control Nurse on 9/14/22 at 10:30 AM, revealed she was	M 640	Housekeeping Supervisor will inspect beds to ensure this deficient practice does not re-occur. The Quality Assurance Committee will address concerns identified on 10/14/22 from checks and evaluate the audit forms completed by the Director of Nursing, Charge Nurse, Assessment Nurse, Staff Development Nurse, or Nurse Case Manager monthly for three months and make any recommendations or changes needed until resolved.	

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M 640	Continued From page 21 Resident # 16's nurse on the night of her fall on 9/12/22. She revealed she was called to the room by CNA # 10 and when she got to the room the resident was lying on her right side in the floor with her head on the end by the head of the bed, legs straight out and arms crossed in front of her. She revealed the resident was holding her left wrist with her right hand. She revealed the resident had a laceration to her head that was bleeding. The left side of the resident's bed was against the wall and a full side rail was up on the right. She revealed the CNA told her that they heard a loud noise like a boom as if something had fallen and that is when CNA # 10 found her around 3:30 AM. She revealed she does not know why the full side rail was ordered or for how long, but the resident was still able to get her legs over the rail because it was short in height. She revealed the resident had falls in the facility before and thinks she has had some injuries. She revealed that the preventative measures that were in place prior to the 9/12/22 fall included checking on and turning the resident every two (2) hours and a full side rail. The nurse usually does rounds in between those 2 hours. On 9/14/22 at 11:01 AM, an interview was attempted with CNA # 10. There was no answer and no voice mail at this time. CNA #5 reported during an interview on 9/14/22 at 2:28 PM, that Resident # 16's care interventions included that she has a full side rail up X (times) one (1) and the other side of her bed was against the wall. She revealed that when the resident was in the bed that one full side rail stayed up all the time and the resident could not let her bed rail down on her own. During an interview on 9/14/22 at 2:42 PM, LPN #	M 640		

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M 640	Continued From page 22 2 stated that Resident # 16's care interventions included one full side rail. She revealed that the full side rail was used for repositioning and confirmed that the resident could not let it down herself. The resident had frequent falls in the past, but it has been a while since her last fall. She revealed the resident was mobile in the bed and could move around. She revealed she has caught her scooted down to the end of the bed with the full side rail up. She would report that to the oncoming nurse, so they could keep a closer eye on her, but she never reported it to the Director of Nurses (DON). She revealed that CNAs had reported that the resident had tried to go over the rail by putting her leg or arm on the rail or was sitting at the foot of her bed and she would just have the CNA's keep a closer eye on her. She revealed she did not think that the resident scooting to the end of the bed or putting her leg or arm on the rail should have been reported to the DON because she had not had an accident like this before. The DON reported during an interview on 9/15/22 at 9:45 AM, that Resident # 16 had three (3) falls prior to this fall since her admission on 4/6/21. She confirmed that the resident's left side of her bed was against the wall and the right side had a full rail when the fall occurred on 9/12/22. She revealed she is not sure why the one full side rail was ordered on 3/15/22. She revealed she does not like the full side rail on beds and will argue with families about having it if they request it, because they just do not understand what those type of siderails can cause. She revealed no staff member had ever reported to her that the resident had attempted to climb over her bed rail. She revealed that the side rail did not prevent her from getting out of the bed but can understand how the full side rail could be considered a	M 640		

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M 640	Continued From page 23	M 640		

restraint and could increase the severity of an injury when the resident has to climb over it to get out of the bed.

The LPN-Infection Control Nurse revealed during an interview on 9/15/22 at 12:15 PM, that she had spoken with one of Resident # 16's CNAs after the fall on 9/12/22 and asked if she had ever seen the resident try to climb over her full bed rail. The CNA confirmed that she had but had never reported it to anyone.

An attempted phone interview on 9/15/22 at 12:42 PM, with Doctor (Dr.) # 1 revealed no answer for his office at this time.

An interview on 9/15/22 at 1:20 PM, with the Administrator revealed she was not aware that Resident # 16 had a bed with a full side rail and if she had known then the resident would not have had it, because we do not use those.

Record review and interview on 9/15/22 at 1:15 PM, with LPN-Medical Records Nurse revealed that RN-Minimum Data Set (MDS) nurse was the nurse that wrote the order for the full side rail on 3/15/22 and Dr. # 1 signed it in 4/2022.

An interview on 9/15/22 at 1:25 PM, with RN-MDS nurse revealed she completed Resident # 16's quarterly assessment on 3/15/22 and when she walked in the resident's room the resident had a full side rail up. RN-MDS revealed that she wrote the order for the full side rail so that it would match what the resident physically had, and her assessment would be correct. RN-MDS revealed she did not report to the DON or anyone else that the resident had a full side rail, because they had several of those beds in the facility at the time and she assumed that was why she had the full

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M 640	Continued From page 24	M 640		

side rail. She revealed she does not know how long the resident had a full side rail prior to her finding it on her 3/15/22 MDS assessment.

An interview on 9/15/22 at 3:15 PM, with Doctor (Dr) # 1 revealed without doing a record review then he does not recall why he ordered a full side rail for Resident # 16. Dr. # 1 revealed he does recall that the resident had dementia, had some falls in the past and had been trying to get out of bed.

Record review of Resident # 16's Face Sheet revealed the resident was admitted to the facility on 04/06/21 with medical diagnoses that included Primary generalized osteoarthritis, Spondylosis without myelopathy or radiculopathy, Alzheimer's disease, and Unspecified dementia without behavioral disturbance.

Record review of Resident # 16's Physician Orders List revealed an order dated 3/15/22, "SIDERAIL (FULL) X 1 FOR BEDMOBILITY".

Record review revealed there was no Side Rail/Restraint Assessment's for Resident # 16

Record review of Resident # 16's X-ray (XR) report from 9/12/22 revealed, "XR Wrist Left PA Lateral and Oblique...Reason for exam: Fall, Swelling...There is an impacted fracture of the distal radial metaphysis and epiphysis and suspected intra-articular extension centrally. There is also a minimally displaced partially impacted fracture at the distal ulnar metaphysis and epiphysis but the styloid appears intact ..."

Record review of Resident # 16's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/22 revealed in Section C a Brief

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M 640	Continued From page 25 Interview for Mental Status (BIMS) of 09 which indicates the resident is moderately cognitively impaired.	M 640		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observations, staff and resident interviews, record reviews, and facility policy review, the facility failed to ensure that oxygen (O2) in use signage was on the door, nasal cannula storage bags were provided, and that nasal cannula storage bags, oxygen tubing, and humidifier bottles were labeled and dated for two (2) of five (5) residents reviewed for oxygen. Residents #29 and #58. Findings include: Review of the facility policy titled, "Oxygen-Administration, Concentrator, Storage, Assemblage," with the latest revision date of 10/17, revealed, "... 13. Post the "NO SMOKING - OXYGEN IN USE" sign on the door of resident's room." Review of the facility policy titled, "Infection Control Oxygen Equipment Cleaning," with the	M 655	Plan of Correction *Oxygen signage placed on #29 door on 9/13/22 by Licensed Practical Nurse. Oxygen storage bag was labeled and placed on resident #29 oxygen concentrator on 9/13/22 by Licensed Practical Nurse. The bottle was replaced and labeled with name and date. Oxygen tubing was labeled and storage bag labeled and placed on concentrator for resident #58 on 9/13/22 by Licensed Practical Nurse. Residents #29 and #58 were assessed for signs and symptoms of respiratory infection on 9/13/22 by Licensed Practical Nurse and 9/14/22 LPN, and no signs/symptoms of respiratory infection were present. All other eighteen oxygen tubing, oxygen bottles and oxygen bags were checked for this deficient practice. * Eighteen residents were identified as having oxygen orders by the Director of Nursing to have the potential to be	10/31/22

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M 655	Continued From page 26 latest revision date of 08/21, revealed, "... 10. When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date. ... When sterile water container is opened, the date will be placed on the container." An observation and interview on 09/12/22 at 11:02 AM, with Resident #29 revealed an O2 concentrator with tubing in the room. There was not an O2 in use sign on the door and no storage bag for nasal cannulas. Resident #29 revealed he had not been given a storage bag for the nasal cannulas but had gotten one in the past when he used oxygen before. An observation and interview on 09/12/22 at 11:27 AM with Resident #58 revealed an O2 concentrator in the room. There was no date on the O2 tubing and the O2 tubing had no storage bag. Resident #58 revealed she does not remember being given a storage bag for her nasal cannulas and she does not wear the oxygen all day. An observation and interview on 9/13/22 at 04:00 PM, with Resident #29 revealed a staff member came to his room and put an "O2 In Use" signage on his door and a staff member had taped a storage bag on his concentrator. The SA did observed the O2 storage bag on the oxygen concentrator with no date, a date on the humidification bottle, but no date on the oxygen tubing. An observation and interview on 9/13/22 a 04:00 PM, with Resident #58 revealed a staff member had taped an O2 tubing storage bag on her oxygen concentrator today. The SA did observe the O2 tubing storage bag on the oxygen	M 655	affected by this deficient practice on 9/13/22. Eighteen residents were assessed by the Director of Nursing, Treatment Nurse, Nurse Case Manager, Assessment Nurse, or Staff Development Nurse for signs/symptoms of respiratory infection on 9/13/22/ and 9/14/22 with no signs/symptoms of respiratory infection noted. *An in-service was begun on 9/14/22 by the Staff Development Nurse on the policy/procedures titled "Oxygen Administration, Concentrator, Storage Assemblage" revised 10/17 and "Infection Control Oxygen Equipment Cleaning" revised 8/21, which includes oxygen storage and labeling of bag when not in use, oxygen signage, humidified water labeling, and labeling of oxygen tubing, with Licensed Practical Nurses and Registered Nurses and continued until all nurses are in-serviced. *The Quality Assurance Committee will address concerns identified from audits and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Treatment Nurse, Nurse Case Manager, and/or Assessment Nurse monthly for three months and make any recommendations or changes needed until resolved on 10/14/22. Beginning 9/19/22, weekly audits of residents with oxygen orders will be conducted by Director of Nursing, Staff Development Nurse, Treatment Nurse, Nurse Case Manager, or Assessment Nurse to ensure compliance related to adherence of ensuring proper labeling of oxygen tubing and humidified water, proper labeling of bags, and proper signage on doors weekly	

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M 655	Continued From page 27 concentrator, but it was not labeled. There was not a date on the humidification bottle or the oxygen tubing. An observation and interview on 9/14/22 at 02:00 PM, with Licensed Practical Nurse (LPN)#5, revealed an O2 in use sign was placed on Resident #29's door when she replaced the humidifier bottle for Resident #29 and Resident #58 on 9/13/22. LPN #5 confirmed Resident #29's and Resident #58's O2 tubing and nasal cannula storage bag was not dated. LPN #5 noted she had not paid attention to there not being any labeling on the O2 tubing and the humidifier bottles and did realize the Resident #29 had not been given a storage bag as of 9/12/22. LPN #5 revealed the nurses are to place an "O2 in Use" signage outside residents' doors that are on O2 therapy, are to date the humidifier bottle, date the O2 tubing, and date the storage bags when replaced and this process should have been done for Resident #29 and Resident #58. An interview on 9/14/22 at 03:00 PM, with LPN #4, revealed residents on O2 therapy should have an "Oxygen in Use" sign on the outside of their door, the O2 tubing, humidifier bottle, and O2 tubing storage bag should be labeled. An interview on 9/14/22 at 03:30 PM, with the Director of Nursing (DON) revealed, the nurses were to place a Oxygen In Use" sign on the outside of residents' doors who are on oxygen therapy, the humidifier bottle and the O2 tubing must be dated, and a storage bag should be provided for nasal cannula storage. The DON revealed she did not think the storage bag required labeling.	M 655	for three weeks and monthly for three months and findings recorded on medical record audit form and maintained by the Director of Nursing.	

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M 655	Continued From page 28 An interview and O2 policy review on 9/14/22 at 3:50 PM, with the DON revealed, the O2 policy noted the oxygen tubing storage bags be labeled with the resident's name, date, and time. The DON confirmed the nurses should have followed the policy for Resident #29 and Resident #58 to ensure each staff member would know the date that the O2 tubing, humidifier bottles, and storage bag was changed to ensure the O2 supplies are changed as scheduled. An interview on 9/14/22 at 3:50 PM, with the Administrator (ADM) confirmed the Federal Regulations noted that the oxygen tubing and humidification bottles should be labeled and there should be a storage bag provided to the residents on oxygen therapy to store the oxygen tubing or masks when not in use. She also confirmed the nurses should have followed the O2 policy, should have provided Resident #29 with oxygen signage, should have dated the humidifier bottles, should have dated the O2 tubing, and should have provided and labeled storage bags for the oxygen tubing for Resident #29 and Resident #58, to ensure all nurses knew when the O2 supplies were last changed. Record review of the for Electronic Treatment Administration Records (ETAR) for Resident #29 and Resident #58 revealed "Label and date tubing, store in plastic bag when not in use." Record review of the diagnoses for Resident #29 revealed diagnoses of COVID-19, Heart Failure, Unspecified, Morbid (severe) Obesity Due to Excess Calories, and Chronic Obstructive Pulmonary Disease, Unspecified. Record review of the "Physician Orders List" for Resident #29 revealed, "Oxygen at 2 Liters via	M 655		

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M 655	Continued From page 29 nasal cannula as needed for Shortness of Breath," dated 8/17/22. Record review of a quarterly Minimum Data Set (MDS) Assessment, with an ARD of 6/29/22 for Resident #29, revealed Resident #29 has a BIMS score of 14, indicating Resident #29 is cognitively intact. Record review of the diagnoses for Resident #58 revealed diagnoses of Unspecified Asthma, Uncomplicated, Nicotine Dependence, Other Tobacco Product, Cough, Chronic Obstructive Pulmonary Disease, Unspecified, and Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris. Record review of the "Physician's Orders List" for Resident #58 revealed, "Oxygen at 2 Liters per nasal cannula as needed for Shortness of Breath," dated 8/15/22. Record review of an annual MDS Assessment with an Assessment Reference Date (ARD) of 5/10/22 for Resident #58, revealed Resident #58 has a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #58 is cognitively intact.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II	M 815	Plan of Correction	10/31/22

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M 815	Continued From page 30 Based on observation, interviews, record review and facility policy review the facility failed to prevent the likelihood of contamination of food utensils as evidenced by a black substance on the wall in the dishwasher area with buildup, debris on a shelf used for drying plate covers and dirty fans for three (3) of four (4) kitchen tours. Findings include: Review of the facility policy titled, "Cleaning and Sanitizing Equipment", with a revision date of 10/17, revealed all equipment is kept clean and food contact surfaces are cleaned and sanitized. All food contact surfaces and work tables are cleaned and sanitized at any time that contamination may occur. An observation on 09/12/22 at 11:05 AM, revealed a buildup of black substance approximately six (6) inches up the wall to the left of the door opening and behind the dishwasher area. A two-tiered polyvinyl chloride (PVC) shelf in the dishwasher room had brown spatters on the bottom PVC pipe and the two (2) shelves were coated with a whitish gray film and brownish debris. An observation, on 09/13/22 at 09:49 AM revealed black buildup on the wall behind the dishwasher area, the 2 tiered shelf continued to have grayish buildup and debris on the shelves and brownish splatters on the bottom PVC pipe of the shelving and two (2) operating fans in the dishwasher room, mounted on the wall had black buildup and rust on the covers. Dietary staff #1 was observed washing dishes and placing the clean plate covers on the dirty shelf to dry. An interview on 09/14/22 at 9:10 AM, with Dietary	M 815	*The walls in the dishwasher area and the shelf for drying plate covers were cleaned on 9/13/22 by the Dishwasher,and the Dietary Manager. One fan was removed from the dishwasher area permanently on 9/19/22 by Maintenance Supervisor. One on one in-service was conducted with dishwasher on 9/13/22 by the Dietary Manager on proper placement of clean dishes after washing. A weekly audit is being conducted by the Dietary Manager to ensure compliance of this deficient practice. *All residents in the facility have the potential to be affected by this deficient practice. None of the potential residents were noted to have any gastrointestinal infections due to the deficient practice. *Beginning 9-13-22, Dietary staff were in-serviced by the Dietary Manager on "Cleaning and Sanitizing Equipment" policy with a revision date of 10/17 which included cleaning of walls in the dishwasher area, shelves for drying plate covers and fans in dietary department and will continue until all dietary staff are in-serviced. Daily cleaning after morning and evening shifts will be conducted. Staff will initial daily cleaning schedule to ensure task completion. *The Quality Assurance Committee will address concerns identified from rounds and review and evaluate the monitoring which began on 9-13-22. The Quality Assurance Committee is scheduled to meet on 10/14/22. The Dietary Manager and/or Administrator will observe the dishwashing area for cleanliness daily for three weeks, and weekly for three months beginning	

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M 815	Continued From page 31 Staff #1 confirmed the black buildup on the wall and she thought it was supposed to be cleaned every day. She stated that she would give the shelf a 6 out of 10 for cleanliness and the shelf should not be dirty because that could cause cross contamination. Dietary Staff #1 confirmed that she was putting clean dishes on the dirty shelves. An interview, on 09/14/22 at 9:15 AM with the Dietary Manager (DM) confirmed the black buildup on the wall and the shelves needed cleaning. The DM washed a small area of the wall and the shelf confirming the buildup could be removed and that this should be cleaned daily. The DM stated that this could cause contamination and confirmed that the plate covers were contaminated and instructed the dietary staff to rewash the plate covers. The DM confirmed the fans needed cleaning and could be blowing causing cross contamination. The DM stated that they had done a deep cleaning of the kitchen on Monday and these issues should have been taken care of Monday. An observation and interview, on 09/14/22 at 9:30 AM, with the Administrator (ADM) confirmed the black buildup on the wall in the dishwasher room and it should be sprayed with bleach and cleaned daily. She confirmed the plate covers were contaminated due to the dirty shelves and that the fans were dirty and could cause contamination and these things could lead to pests. An interview on 09/14/22 at 10:20 AM, with the Infection Control Nurse (ICN) revealed that contaminated dishes in the kitchen could cause resident illnesses like upset stomach, nausea, vomiting and diarrhea. The ICN confirmed there had not been any gastrointestinal infection	M 815	9/13/22.	

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M 815	Continued From page 32 outbreaks in the facility. Record review of the Daily Cleaning Sanitizing Schedule revealed that the dish machine area should be cleaned three times a day and the cleaning schedule had not been followed for 11 of 13 days reviewed from 9/1/22 through 9/13/22.	M 815		