STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255269	A. BUILDING _____ B. WING _____	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD HEALTH & REHAB CENTER	1301 BELK BOULEVARD OXFORD, MS 38655

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation CI MS #21115 at the facility from 5/9/23 through 5/12/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F580, F584, F637, F656, F660, F677, F689, F758, and F812. The SA found the facility to be in compliance related to CI MS #21115 and no deficiencies were cited. The census at the time of the survey was 108 and the facility was licensed for 120 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		6/25/23

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

Electronically Signed | 05/25/2023

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F 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to communicate a medical change in condition of a resident with edema in the hand and wrist for one (1) of 23 residents reviewed. Resident #16 Findings include: Review of the facility policy titled, "PHYSICIAN	F 580	• Resident #16 was reassessed by Licensed Practical Nurse and unit charge nurse on 5/10/2023 to verify swelling to the left hand. The physician and the resident's representative were notified on 5/10/2023 upon completion of the assessment that the resident's left hand was swollen. No new orders were received by the facilities physician upon notification.	

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F 580	Continued From page 2 VISITS AND MEDICAL ORDERS," with a revised date of 11/28/2017, revealed " ... POLICY: the attending physician shall prescribe the medical regimen of care for the residents he/she admits. The attending physician must directly supervise the activities leading to the treatment of the resident." Review of the facility policy titled, "NOTIFICATION OF CHANGE IN RESIDENT'S CONDITION," with a revised date of 11/28/2017, revealed "POLICY: Physicians ... shall be notified, as soon as possible, of any changes in the resident's condition." An observation and interview on 05/10/23 at 12:24 PM, with Resident #16, revealed her left hand was swollen from approximately 2 inches above the wrist to the end of her fingers. She provided information about the nurse being aware of the swelling in her left hand. She noted her hand had been swollen for a few weeks, that she did not know why, and she did tell the nurse so she could get some help with getting it to go down. Resident stated that she has had a stroke on the left side of her body, but her hand hasn't swollen like this before and that she doesn ' t recall injuring it recently. An interview on 5/10/23 at 4:17 PM, with Licensed Practical Nurse (LPN)#6, revealed he was aware of the swelling in Resident #16's left wrist and hand and that the swelling had been there for a few weeks. LPN #6 stated that the resident liked to sleep on her left side, but he wasn ' t sure what had caused the swelling because she had not had any recent injury or falls that he was aware. He revealed he had not documented the information in the medical record	F 580	• All residents have the potential to be affected. • Staff educator will conduct an in-service with nursing staff on notification of change beginning 5/12/2023. • Quality Assurance nurse will conduct an audit of 3 residents weekly for 4 consecutive weeks and then biweekly for 3 months beginning on 5/26/2023. These residents will be assessed to ensure that any declines in condition from resident's baseline status have been identified, properly evaluated, and communicated to the nursing supervisor, physician, and responsible party. The findings of this audit will be discussed with the Quality Assurance Committee beginning 6/16/2023 until such a time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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F 580	Continued From page 3	F 580		

regarding finding the swelling, that he had not called the physician to inform him of the physical changes with Resident #16 or to request orders for follow up care needs. He revealed he was not sure what could have caused the swelling but had informed the Charge Nurse lately about it, but she was not at work today.

An observation and interview on 5/10/23 at 4:30 PM, of Resident #16's left wrist and hand, with Registered Nurse (RN) Charge Nurse #3, revealed she was not aware Resident #16 had swelling to her left wrist and hand. She noted she rounded daily on all the residents, had rounded on Resident #16 today, but did not see her swollen left wrist and hand because she did not complete a total body audit. She revealed none of the nurses that had been assigned to Resident #16 for the past few weeks had informed her that Resident #16 had a swollen left wrist and hand. She confirmed through observation that Resident #16 did have swelling noted approximately 2 inches above her left wrist and that the edema extended to the end of Resident #16's fingers on the left hand.

An interview on 5/10/23 at 5:05 PM, with the Director of Nursing (DON) revealed she was not aware that Resident #16 had edema approximately 2 inches above her left wrist, that extended down her hand to the ends of her fingers. She confirmed the LPN should have told each Charge Nurse about the findings of edema in Resident #16's left wrist and hand, that he should have documented the findings and that the physician should have been notified immediately to allow Resident #16 to be assessed for the possible need of follow up and/or possible new orders for care. The DON

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F 580	Continued From page 4 also confirmed Resident #16 did not receive treatment and care according to professional standards of practice. Record review completed of the "Departmental Notes" for April 2023, and May 9, 2023, for nurses' progress notes for Resident #16, revealed no documentation regarding the edema in Resident #16's left wrist and hand, and revealed no documentation regarding the Charge Nurses, the DON, or the physician being notified of the edema in Resident #16's left wrist and hand observed by LPN #6. Record review of the "Face Sheet" for Resident #16 revealed an admission date of 11/01/21, with a diagnosis of Unspecified Sequelae of Unspecified Cerebrovascular Disease. Record review of Section C of the Significant Change Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/10/2023, for Resident #16, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident is cognitively intact.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		6/25/23

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F 584	Continued From page 5 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and facility policy review the facility failed to maintain and provide a clean and homelike environment for two (2) of 23 residents reviewed. Resident #13 and #38 Findings include:	F 584	• On 5/10/2023 resident #13's wheelchair was cleaned by Registered Nurse manager. On 5/11/2023, resident # 38's walls were repaired, the bedside table was replaced, the bed was replaced, the window blinds were replaced, and pictures were hung in the room.	

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F 584	Continued From page 6 Review of the facility policy titled, "Resident Environment" with a revision date of 11/28/2017, revealed this facility shall create and maintain a supportive environment for all residents, which preserves dignity and facilitates a positive self-image. The facility provided documentation on letterhead dated 5/11/23 that read, "This facility does not have a policy regarding the cleaning of wheelchairs." Resident #13 An observation on 05/10/23 at 8:05 AM, revealed Resident #13 sitting in a wheelchair in the hallway. The resident's wheelchair was noted with a thick layer of dried brown substance adhering to the lower bars and frame of the wheelchair. An interview on 05/11/23 at 8:30 AM, with Certified Nurse Aide (CNA) #3 revealed that the night shift was responsible for cleaning the residents' wheelchairs. An interview and observation on 5/11/23 at 8:34 AM, with Registered Nurse (RN) #1, confirmed that Resident #13's wheelchair had a thick layer of dried brown substance adhering to the lower bars and the lower frame. She stated, "Yes, I see what you're saying." She revealed that the night shift CNA's were responsible for cleaning the resident's wheelchairs, but they did not have a set cleaning schedule. An interview and observation on 5/11/23 at 8:56 AM, with the Director of Nursing (DON) acknowledged that Resident #13's wheelchair had a dried brown substance adhering to the	F 584	• All residents have the potential to be affected. • An in service will be completed by the Staff Educator with all Certified Nursing Assistants on wheelchair cleaning and the wheelchair cleaning schedule beginning on 5/29/2023. • The administrative staff will conduct room rounds 3 times a week, for 4 weeks, then weekly for 3 months beginning on 5/30/2023. Staff will report any damage to the administrator. A wheelchair cleaning schedule was implemented on 5/10/2023. The Quality Assurance nurse will audit 10 wheelchairs weekly for 4 weeks and then biweekly for 3 months beginning 5/30/2023. This plan of correction will be monitored at the monthly Quality Assurance meeting until such a time consistent, substantial compliance has been met beginning 6/16/2023. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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F 584	Continued From page 7	F 584		

lower bars and frame. She agreed that the residents' equipment should be cleaned and stated that the night shift CNA's was responsible for the cleaning of the wheelchairs and they have a schedule to determine which wheelchairs need cleaning on which nights. However, she could not provide any documentation of a wheelchair cleaning schedule.

Record review of the Face Sheet revealed Resident #13 was admitted to the facility on 9/10/20 with medical diagnoses that included Unspecified Intellectual Disabilities, Down Syndrome, unspecified and Anxiety disorder.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/14/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 99, indicating Resident # 13 was unable to complete the BIMS.

Resident #38
An observation, on 05/09/23 at 11:33 AM, revealed Resident #38 in bed. The resident's overbed tray table had 3/4 of the brown coating scraped off the top and had the wood exposed. The upper siderails of the bed were dirty and the left side handrail was cracked approximately six to seven (6-7) inches and was rough to the touch. The side rail on the bed had a brownish substance that had run down the side rail and dried. The window blinds were broken and bent. Resident #38 was in a private room, there were no pictures, wall decorations or any other personal items observed in the room. The room was bare except for essential items, bed, overbed table and bedside table and a small television. There was an area on the wall by the bed that

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F 584	Continued From page 8	F 584		

had an irregular one by three (1x3) foot area with the paint scuffed off the wall.

An interview on 5/10/23 at 2:30 PM, with Resident #38 revealed he would like to have some pictures on the wall and would like his bed moved in the room where he could see out the window. The resident denies any injury but stated the side rails need fixing because he could "skin his arms."

An observation and interview on 5/11/23 at 2:40 PM, with the Marketing Director, who stated he is an Assistant Social Worker and the Social Service Director confirmed the resident's room was bare and the overbed tray table had most of the surface peeled off.

An observation and interview on 5/11/23 at 2:50 PM, with the Director of Nursing (DON) revealed the window blinds were bent and broken and she stated that they need to be replaced. She stated that Resident #38's overbed table needed to be replaced, his wall needed to be repaired and his side rail needed to be cleaned and the torn area needs to be repaired or replaced. She confirmed that the side rail needed to be repaired because it could cause a skin tear.

An interview with the Marketing Director revealed he should have noticed the overbed table and the side rails. He stated that he is assigned to Resident #38's room daily to make rounds and notify if repairs need to be made and stated that he needs to do better observing for these things.

Review of the facility Face Sheet for Resident #38 revealed an admission date of 1/21/21 with diagnoses that included Hemiplegia following Cerebral Infarction affecting left nondominant

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F 584	Continued From page 9 side and Anxiety. Review of the MDS with an ARD of 3/24/23 revealed Resident #38 had a BIMS score of 03 which indicated severe cognitive impairment.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review the facility failed to complete a Significant Change Minimum Data Set (MDS) Assessment within 14 days for a resident with a physical and mental decline for one (1) of 23 sampled residents. Resident #16 Resident #16 Review of the facility policy titled, " COMPREHENSIVE ASSESSMENT AND RE-ASSESSMENT," with a revised date of 11/27/2017, revealed " ... POLICY: The assessment of the care or treatment required to meet the needs of the resident shall be ongoing	F 637	• The significant change for resident #16 was completed by the Minimum Data Set (MDS) nurse on 3/10/23. • All residents have the potential to be affected. • On 5/23/2023 facility MDS nurses were in serviced by Administrator on completing a significant change in a timely manner. • The Director of nursing will audit significant changes being completed by MDS daily Monday – Friday during the	6/25/23

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F 637	Continued From page 10 throughout the resident's facility stay, with the assessment process individualized to meet the needs of the resident population. The facility shall comply with Resident Assessment Instrument (R.A.I.) guidelines for comprehensive assessments and re-assessments to determine significant status changes in cognitive and/or physical condition. ... A comprehensive reassessment shall be completed ... within 14 days after it is determined that there has been a significant change in the resident's physical or mental condition." Record review of the Significant Change Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 3/10/23 revealed the assessment was completed related to a significant physical change that was identified in January 2023. An interview on 5/11/23 at 12:00 PM, with Restorative Care Aid #5, revealed she did have Resident #16 admitted for Restorative Therapy in January 2023, because of a physical decline, falls, and increased confusion. She noted Resident #16 was not getting any better with the Restorative Therapy and was then placed on Physical Therapy (PT) in February 2023. An interview on 5/11/23 at 3:30 PM, with the MDS Nurse confirmed she completed the MDS Significant Change Assessment with an ARD of 3/10/23 based on the physical decline that began in January 2023. She noted Resident #16 had restorative therapy in January 2023 and did not progress. Resident #16 was then admitted to therapy services in February 2023. The Therapy Director informed her in March 2023 of Resident #16's significant physical decline, after Resident	F 637	stand down meeting beginning 5/30/2023 for 4 consecutive weeks and then biweekly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such a time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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#16 was discharged from therapy and that she had met her goals and improved. She revealed she felt the significant change assessment needed to be done since Resident #16 had a decline in January 2023 and required therapy to improve. She confirmed the MDS Significant Change Assessment, with an ARD of 3/10/23, for Resident #16, was not completed in 14 days of Resident #16's noted significant physical change/decline.

A record review and interview on 5/11/23 at 3:55 PM, with the Director of Nursing (DON) revealed Resident #16 was noted to have had a significant decline in her physical and mental independence, and that she started to require 2-3 people assist at times for Activities of Daily Living (ADLs), and that Resident #16 had been previously totally independent. She also noted Resident #16 had increased confusion during the time when she suffered her physical decline. She confirmed that there was no nursing documentation in the computer for the progression of the physical and mental decline and the periods of confusion expressed for Resident #16. The DON confirmed there was documentation of a fall in October 2022 and January 2023. The DON confirmed that the MDS Significant Change Assessment with an ARD of 3/10/23 was not submitted within 14 days of her significant physical and mental decline.

An interview on 5/12/23 at 11:30 AM, with the Rehabilitation (Rehab) Director revealed he informed the MDS Nurse that Resident #16 had a significant change of improvement, not a significant decline for the Significant Change MDS Assessment that was done on 3/10/23.

An interview on 5/12/23 at 3:15 PM, with the

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F 637	Continued From page 12	F 637		

Administrator confirmed that the MDS Nurse did not complete a timely Significant Change MDS Assessment for Resident #16 and that it should have been completed within 14 days after her significant physical and mental decline began.

Record review of the "Departmental Notes" for Resident #16, revealed " ... 2/2/2023 1:40 PM IDT MET TO REVIEW RECENT FALLS RESIDENT HAD A FALL ON 1/31/23 AT 12:55 AM." The record review did not reveal that the fall was related to a physical or mental decline.

Record review completed of the nurses' progress notes for January 2023 and for February 2023 to March 9, 2023, for Resident #16, revealed there was no documentation regarding a physical or mental decline for Resident #16.

Record review of the "Physical Therapy Plan of Care" for Resident #16 revealed " ... MEDICAL DIAGNOSIS ... Unspecified dementia, unspecified severity, with other behavioral disturbances ... TREATMENT DIAGNOSIS ... Unsteadiness on feet ... Other abnormalities of gait and mobility ... Other lack of coordination ... START OF CARE 02/02/2023; END OF CARE 03/15/2023 ... Reason For Referral: (Resident #16's name removed) is a 86 y/o female and long term resident who was recently referred to PT d/t pt fall on 1/31/2023 ... Pt's prior level of function was: independent for functional mobility ... Pt presents to physical therapy with decreased endurance (fair), decreased transfer ability (min-mod (a)) d/t weakness and decreased coordination in (B) LE, impaired gait d/t (b) LE weakness and deconditioning, and impaired balance (f-) secondary to decreased safety awareness and weakness, activity limitations, and

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F 637	Continued From page 13 participation restrictions of inability to bathe IND (independant), completed light room chores, completed ADLs, ambulate functional distances with in room, and completed WC (wheelchair) mobility for community." Record review revealed that Resident #16 was admitted to the facility on 11/02/21 with a diagnosis which included Cerebrovascular Disease and Lack of Coordination. The resident had a most recent MDS with an ARD of 3/10/23 that revealed a BIMS score of 12 revealing that the resident was moderately impaired with cognition.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		6/25/23

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F 656	Continued From page 14 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review the facility failed to develop and implement a care plan for a resident providing self-care with a colostomy for one (1) of 23 residents care plans reviewed. Resident #15 Findings include: Review of the facility policy titled, "COMPREHENSIVE PLAN OF CARE," with a revised date of 10/10/2022, revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for	F 656	• On 5/11/2023 resident #15 was reassessed by the treatment nurse and agreed to allow treatment team or nursing staff to change and care for her ostomy. A skin assessment was completed by the treatment nurse on 5/11/2023 with no negative findings. The physician was notified, and new orders were received for colostomy care to begin on 5/12/2023. Resident #15's care plan was updated on 5/11/2023. • All residents with an ostomy have the potential to be affected.	

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F 656	Continued From page 15 each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Record review of the care plans for Resident #15 revealed she did not have a care plan developed for self-care of her colostomy. An interview on 05/09/23 at 10:44 AM, with Resident #15 revealed she cleaned and changed her own colostomy wafer and colostomy bag as needed. The State Agency (SA) observed two (2) new ostomy bags were on Resident #15's bedside table and noted that the staff brought ostomy supplies to her room for the resident to use as she needed. An interview on 5/10/23 at 4:40 PM, with Registered Nurse (RN)#2, confirmed Resident #15 completed her own colostomy care that included changing the barriers and changing the colostomy bags. An interview on 5/10/23 at 4:45 PM, with RN Charge Nurse #3 confirmed Resident #15 provided her own colostomy care with no care plan and that she was aware that Resident #15 had been doing her own colostomy care. An interview on 5/10/23 at 4:50 PM, with the Care Plan Nurse confirmed there was not a care plan developed for Resident #15 to do self-care with her colostomy. She revealed she was aware that Resident #15 was caring for her own colostomy and thought there was a care plan for the self-care of the colostomy in the electronic health record (EHR) for Resident #15. She confirmed	F 656	• Beginning 5/30/2023 staff educator will in service treatment team and nursing staff on providing proper ostomy care and skin assessments. • The unit charge nurses will conduct colostomy care checks 3 times weekly for 4 consecutive weeks and then biweekly for 3 months ensuring proper colostomy care and documentation. Colostomy checks began on 5/11/2023. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such a time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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F 656	Continued From page 16 that a care plan should have been developed for Resident #15 regarding self-care of her colostomy. An interview on 5/10/23 at 5:05 PM with the Director of Nursing (DON) confirmed Resident #15 was providing self-care of her colostomy. She confirmed that Resident #15 did not have a care plan developed for her to perform self-care of her colostomy. The DON also confirmed that a care plan should have been developed for Resident #15 regarding self-care of her colostomy. Record review of the "Face Sheet" for Resident #15 revealed an admission date of 7/21/20, with diagnoses of Other Symptoms and Signs Involving the Digestive System and Abdomen and Encounter for Attention to Colostomy. Record review of the Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/08/2023, for Resident #15, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #15 is cognitively intact.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge	F 660		6/25/23

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rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

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F 660	Continued From page 18 (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to complete the discharge planning process for a resident that requested to transfer to another nursing facility for one (1) of four (4) residents reviewed. Resident #1 Findings include: Review of the facility policy titled, "TRANSFER AND DISCHARGE," revised 10/18/2022, revealed "c. Orientation for transfer or discharge must be provided and documented to ensure safe	F 660	• Resident #1 was discharged from the facility on 3/9/2023. • All residents who plan to discharge from the facility have the potential to be affected. • The licensed social worker has been in serviced by the company's social work consultant on proper discharge planning on 5/19/2023. • Quality Assurance nurse will audit 3	

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F 660	Continued From page 19 and orderly transfer or discharge from the facility ... this orientation may be provided by various members of the interdisciplinary team ... e. The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge ... g. Supporting documentation shall include evidence of the resident's or resident representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative." An interview on 5/11/23 at 9:30 AM, with Social Services revealed that Resident #1 had asked to be transferred to another nursing facility closer to his home in August 2022 but the Social Services department did not document it until March 7, 2023.. She confirmed she did not document her conversation with Resident #1 regarding his discharge planning request to go to another nursing facility closer to home. She stated she did not have a discharge care plan meeting, nor had she updated his discharge care plan regarding Resident #1's request to go to another nursing facility. She also confirmed that she had not developed a discharge plan with the interdisciplinary team to work on discharge to another nursing facility and had not documented that referrals were sent out to other nursing facilities. She confirmed she had not documented the response from any of the nursing facilities regarding the referrals sent out for Resident #1. She noted she did not know she had to document responses from referrals and was not aware she had to document everything that was done for a resident's discharge planning process in the medical record. She confirmed that none of the facilities had accepted Resident #1 until March	F 660	discharges a week for 4 consecutive weeks and then biweekly for 3 months to ensure proper discharge planning is done. Audits will begin 5/30/2023. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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2023 and that she waited until he was accepted by another nursing facility to fill out a Discharge Assessment Guide and plan the discharge on 3/1/23.

An interview on 5/11/23 at 10:00 AM, with the Director of Nursing (DON) revealed she was not involved in a care plan meeting regarding the discharge plan of Resident #1 and was not aware of any documentation regarding the discharge plan from Social Services. The DON noted there was no nursing documentation related to discharge planning.

An interview on 5/11/23 at 10:30 AM, with the Administrator confirmed Social Services had not documented regarding the discharge planning process for Resident #1 and there had not been an interdisciplinary approach for the discharge plan for Resident #1. The Administrator confirmed that there was no discharge care plan updated for Resident #1 and Social Services did not follow the discharge planning process for Resident #1.

Record review of the "Departmental Notes," for Resident #1, revealed there was no documentation regarding an interdisciplinary team meeting for discharge planning for Resident #1.

Record review of the "Discharge Assessment Guide and Plan," dated 3/1/23, for Resident #1 revealed " ... Special Instructions: DC (Discharge) to (Proper name of a facility). ... Community Agencies to Be Contacted: (Proper Name of facility) to follow up referral." Documentation revealed that the "Discharge Assessment Guide and Plan" was not fully completed.

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F 660	Continued From page 21 Record review of the Physician's Orders dated 3/8/23 revealed an order "Discharge to (Formal name of nursing facility) on 3/9/2023..." Record review of the Face Sheet for Resident #1 revealed an admission date of 3/22/22, with a diagnoses that included Nicotine Dependence, Cigarettes, Uncomplicated. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/06/2023, revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #1 is cognitively intact.	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to provide adequate mouth care to a resident who is dependent on staff for care for one (1) of 108 residents observed for personal care and hygiene. Resident #47 Findings include: Review of the facility policy titled, "Increasing Resident Independence, Provision of Care, Treatment, and Service: Resident and Family Education", with a revision date of 11/28/2017, revealed facilities shall promote an atmosphere of respect for human dignity in the provision of	F 677	• Resident #47 was reassessed by unit charge nurse on 5/11/2023 to verify resident's lips were dry. Unit charge nurse applied lip moisturizer and performed oral care. Physician order was written for oral care every 4 hours and as needed (PRN). This was added to the residents Medication Administration Record (MAR) for completion. • All residents have the potential to be affected. • A 100% audit of all NPO residents was conducted by Assistant Director of	6/25/23

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F 677	Continued From page 22 healthcare and services provided by the facility. Healthcare providers shall encourage resident independence to engender increased resident self-esteem and confidence. The procedures include ADL (Activities of Daily Living) shall be performed by healthcare providers for those residents who are unable to perform the activities themselves, or who do not have support from family. An observation on 05/09/23 at 5:06 PM, revealed Resident #47 had tube feeding formula infusing. The mucous membranes of Resident #47's mouth and lips were dry with a white line around the top and bottom lips. On 05/10/23 at 2:59 PM, an observation revealed Resident #47's lips were dry and cracked. An observation on 5/11/23 at 8:55 AM, revealed Resident # 47 in bed with dry white flakes on her lips. An observation on 05/11/23 at 9:30 AM, revealed the resident continued to have dry cracked lips with white flakes on her lips. An observation and interview on 5/11/23 at 9:40 AM, with Certified Nursing Assistant (CNA) #1 revealed that she does mouth care on Resident #47 every time she makes rounds. She stated she uses lemon glycerin swabs, but the resident's lips are dry and has scabbing and rubbing them with the swabs or a bath cloth will make them bleed. CNA #1 confirmed the resident's lips should not look like they do with hard dry skin on them. An observation and interview on 5/11/23 at 9:42	F 677	Nursing on 5/11/2023 to ensure proper oral care. • Unit charge nurse will audit 5 residents weekly, Monday – Friday for 4 consecutive weeks to ensure proper oral care is being performed then audit will continue biweekly for 3 months. Audits will begin 5/30/2023. Beginning 5/29/2023 an in service on proper oral care will be conducted by the Staff Educator for nursing staff and certified nursing assistants. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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F 677	Continued From page 23 AM with the Assistant Director of Nursing (ADON) stated the Resident #47's lips did not look good and confirmed that they were dry and cracked. She stated that they need to find something else to put on her lips to keep them moistened. Review of the facility Face Sheet for Resident #47 revealed an admission date of 5/4/2017 and a readmission date of 11/16/21 with diagnoses that included Downs Syndrome, personal history of Venous Thrombosis and Emboli, and Dysphagia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/23 revealed no Brief Interview for Mental Status (BIMS) score due to Resident #47 being severely impaired-never/rarely made decisions.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, facility policy review the facility failed to ensure the environment is free of potential accident hazards as evidenced by unattended medications left on bedside table for two (2) of 108 residents reviewed. Resident # 356 and #362	F 689	• Resident #362 was discharged from the facility on 5/12/2023. Resident #356 still resides at the facility. On 5/10/2023 Director of Nursing assessed resident with no negative findings. On 5/10/2023 Registered Nurse (RN) unit supervisor assessed each resident assigned to LPN #1 to ensure no other medications were	6/25/23

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F 689	Continued From page 24 Findings include: Record review of the facility policy titled, "Medication Administration" with a revision date of 06/27/19 revealed "Policy ... No medication shall be left at the resident's bedside unless the following is available: Physician order; Self-administration of medication assessment; Care plan ...The nurse administering the medication shall stay with the resident until the medication is taken ..." An observation and interview with Resident #356 on 05/09/23 at 11:10 AM, revealed a light green oval capsule inside a clear medicine cup on the bedside table. The State Agency (SA) inquired whether the resident could self-administer her medications and Resident #356 stated," They bring in my medicine, sit it down on the table, and I take it." The resident confirmed that the capsule on the bedside table was her medication. An observation on 05/09/23 at 3:45 PM, of Resident #356's bedside table revealed a light green capsule inside a clear medicine cup. Record review of the Face Sheet revealed Resident #356 was admitted to the facility on 3/17/23 and re-admitted on 4/11/23 with medical diagnoses that included Displaced Intertrochanteric Fracture Left Femur, subsequent encounter for closed fracture with routine healing, and Aftercare Following Explanation of Hip Joint Prosthesis and Anemia, unspecified. Record review of the 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/18/23, revealed under section C a	F 689	left at the bedside. • All residents have the potential to be affected. • On 5/10/2023 a 100% facility room audit was conducted by the Director of Nursing to ensure proper medication administration to ensure no medications were left at the residents bedside. • Quality Assurance nurse will audit weekly, Monday – Friday 10 resident rooms for 4 consecutive weeks to ensure proper medication administration and then biweekly for 3 months. Audits will begin 5/30/2023. Staff educator will in service all nursing staff on medication administration beginning 5/12/2022. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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	255269	A. BUILDING _____ B. WING _____	05/12/2023

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Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident # 356 is cognitively intact.

Resident #362

An observation on 5/9/23 at 11:40 AM, of Resident #362's bedside table revealed a bottle of nasal spray, a bottle of eye drops, an inhaler, and a bottle of roll-on Lidocaine.

Observation and interview on 05/09/23 4:35 PM, with Resident #362 revealed Flonase nasal spray, artificial tears eye drops, lidocaine roll on and an albuterol inhaler on bedside table. Resident #362 verified that the medications were hers and stated that a nurse brought the medications to her and told her the medications were left over from a previous stay at the facility. Resident stated that the lidocaine roll on belongs to her husband and he uses it during the day while he visits. She revealed she knows how to administer the albuterol inhaler and artificial tears and uses them as needed and stated she uses the Flonase nasal spray once daily.

Record review of the Face Sheet revealed Resident #362 was admitted to the facility on 4/14/23 with medical diagnoses that included Other Specified Disorders of Muscle, History of Falling, and Epilepsy, unspecified not intractable, without status epilepticus.

Record Review of the Minimum Data Set (MDS) Admission 5-day assessment with an Assessment Reference Date (ARD) of 4/21/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 14, which indicates Resident #362 is cognitively intact.

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An interview on 05/10/23 at 5:05 PM, with Licensed Practical Nurse (LPN) # 1 revealed that when she administered medication to a resident, she always stayed in the room to ensure that the resident swallowed the medication and did not choke or spit it out. She revealed that by leaving the medicine in the room, a confused person could wander into the room and take it. She confirmed that neither Resident # 356 or Resident #362 has a physician's order or a care plan to self-administer medication.

An interview on 05/10/23 at 5:15 PM, with Registered Nurse (RN) #1 acknowledged that the staff should never leave medicine in a resident room unattended. She stated that it is not safe to leave medications unattended at a resident's bedside. She revealed that neither Resident # 356 or Resident # 362 has a physician's order or a care plan to self-administer her medications.

An interview on 05/10/23 at 5:25 PM, with Certified Nurse Aide (CNA) #2 revealed that if she noticed medicine in a resident's room unattended, she immediately notified the nurse. She revealed that a confused resident could accidentally take the medicine without understanding the danger.

An interview on 05/12/23 at 9:01 AM, with the Director of Nursing (DON) acknowledged that medicine should not be left in a resident's room. She stated that the nurse should stay with the resident to ensure that the resident took the medication. She revealed by leaving the medicine in the room, the resident could miss a dose, or someone else could wander into the room and take the medicine.

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F 758	Continued From page 27	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		6/25/23

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F 758	Continued From page 28 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, consultant pharmacy interview, record review and facility policy review the facility failed to provide a 14- day stop date on psychotropic medications for one (1) of 23 sampled residents. Resident #68 Findings include: Review of the facility policy titled, "Psychotropic Medication Use", revealed it is the facility's policy that each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, free from unnecessary drugs. As needed (PRN) orders for psychotropic drugs will be limited to 14 days unless prescribing physician believes that the drug should be prescribed beyond the 14-day period. The rationale for extending the use and the indicated duration shall be documented in the resident's medical record. Resident #68: Record review of the physician orders for Resident #68 revealed an order dated 1/12/23 for	F 758	• Resident #68 still resides in the facility. On 5/11/2023 resident #68 was assessed by the Director of Nursing with no negative findings. On 5/11/2023 nursing staff received communication from the physician to update residents as needed (PRN) psychotropic medication with a 14 day stop date. • All residents receiving psychotropic medication have the potential to be affected. • A 100% audit on all as needed (PRN) psychotropic medications was completed on 5/11/2023 by the Quality Assurance nurse. Orders were corrected as necessary. • The quality assurance nurse will audit 5 PRN psychotropic medications a week for 4 consecutive weeks to ensure proper psychotropic medication use and then biweekly for 3 months beginning 5/11/2023. Staff educator will in service all nursing staff on the use of psychotropic	

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F 758	Continued From page 29 Ativan 2 milligrams (mg)/milliliter (ml) vial, give 0.5 ml sublingual (SL) every (Q) 4 hours (H) prn (anxiety/agitation). The order does not have a stop date. An observation and interview on 5/11/23 at 9:30 AM with Licensed Practical Nurse (LPN) #6 confirmed Resident #68 had an order for as needed Ativan and that it should have a stop date of 14 days. He stated that he had not noticed it because he had not given the medication. An observation and interview on 5/11/23 at 9:42 AM with Assistant Director of Nursing (ADON) confirmed Resident #68 had an order for as needed Ativan sublingual. She stated that the order should have a stop order date. A telephone interview, on 5/11/23 at 9:50 AM with the Consultant Pharmacist, revealed the Ativan as needed order should have a stop date. He stated that he reviewed the order and sent a recommendation to the physician. He stated they (the physicians) have been instructed on the need for written justification for not giving a stop date. An interview on 05/11/23 at 10:00 AM with the Director of Nursing (DON) confirmed that orders for as needed Ativan should have a stop date and confirmed that the physician's order for Resident #68 did not have a stop date for the medication order. Record review of the consultant pharmacist recommendation to physician revealed due to Centers for Medicare and Medicaid (CMS) requirements for (PRN) as needed psychotropic medications, consider adding a 14-day duration or consider changing to a scheduled frequency if	F 758	medications with an emphasis on as needed (PRN) psychotropic drugs being limited to 14 days. In service will begin on 5/29/2023. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such a time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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F 758	Continued From page 30 receiving routinely. Under Physician/Prescriber Response, which included agree, disagree, and other, other was checked with a statement that revealed "Patient is on hospice and close monitoring." Review of the facility Face Sheet for Resident #68 revealed an admission date of 4/16/22 with diagnoses that included Perineural cyst and Metabolic Encephalopathy. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/26/23 revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated Resident #68 had moderately impaired cognition.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		6/25/23

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F 812	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review the facility failed to ensure items in the kitchen refrigerator and freezer were dated and labeled for one (1) of three (3) dietary observations. Findings include: A review of the facility policy titled, "Food Storage" with an initial date of 2021 and a revision date of 3/22 revealed "All foods should be covered, labeled, and dated, and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded." On 05/09/23 at 10:15 AM, observation and interview of the kitchen with the Dietary Manager (DM) and Dietary Staff #1 revealed in the standing freezer noted a manufactured bag of a food product that was unlabeled and undated. Dietary Staff #1 revealed "that's Panko Chicken tenders" and stated she wasn't sure of when it was opened. She confirmed that the food was not labeled and dated, and it should be. In the main standing Walk-in Cooler revealed a pie with approximately 3/4 remaining. Dietary Staff #1 revealed this an a apple pie and needed to be thrown away because it did not have a date. There was a large rectangular aluminum pan with a brown substance on the lid with no label or date. Dietary Staff #1 revealed there are hotdog's in here and I think the brown substance may have been from where it was in the oven, and something leaked on the top of it. There was a large rectangular aluminum pan with a lid was observed with no label, it had a date of 5/2 and a	F 812	• On 5/9/2023 all opened unlabeled and undated food was discarded from the kitchen. • All residents have the potential to be affected. • Dietary managers and dietary staff were in serviced on 5/11/2023 by the dietary district manager on proper food labeling, food expiration dates, storage, and procurement. Dietary managers will hold monthly in services on proper food labeling, storage, and procurement beginning 5/19/023. • Infection control nurse will audit the kitchen coolers, freezers, food expiration dates, and storage areas daily Monday – Friday for 4 consecutive weeks beginning 5/30/2023 and then biweekly for 3 months. This plan of correction will be monitored at the monthly Quality Assurance meeting beginning 6/16/2023 until such time consistent, substantial compliance has been met. This plan of correction will be discussed at the monthly Quality assurance meetings at minimum for the next 6 months. • Corrective action completion date: June 25, 2023	

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F 812	Continued From page 32	F 812		

line drawn underneath with the date of 5/5. Dietary Staff #1 identified the food as green bean casserole and revealed that 5/2 was the date it was put in the refrigerator and 5/5 was the date it was supposed to be discarded by. There was a large rectangular aluminum pan with a lid observed with no label or date. Dietary Staff #1 identified the item as being chicken and dumplings and confirmed there were no dates and labels but there should be. Observed one (1) quart-size bag with lettuce, (1) quart-size bag with onions, and (1) quart-size bag of sliced tomatoes were unlabeled and undated. The DM identified the food items in each bag and revealed they should have been labeled and dated and that it is their policy to keep foods labeled and dated. The DM disposed of all unlabeled and undated food items from the standing freezer and walk-in cooler.

An interview on 05/09/2023 at 11:05 AM, the DM revealed the dietary staff that puts the food in the refrigerator or freezer is responsible for labeling and dating the food item and then management is responsible to check the refrigerators/freezers the first thing each morning to make sure things are labeled and dated and there are no expired foods. The DM confirmed that food items were not being labeled and dated and revealed these foods could make a resident sick.