STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255102	A. BUILDING _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey and Complaint Investigation (CI) MS #22574 at the facility from 08/29/23 through 08/31/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies at F 558, F 584, F 645, F 656, F 677, F 689, F 761, and F 812. CI MS #22574 was investigated related to Quality of Care and Resident verbal abuse and the facility was found to be in compliance. The census at the time of the survey was 121 and the facility has beds for 131 residents.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review the facility failed to provide the correct size sling for a resident who needed to be transferred with a total lift (Resident #26) and to provide easy access to a resident's personal restroom (Resident #99) for two (2) of 121 residents reviewed for accommodations during the survey. Findings include:	F 558	F558 – Reasonable Accommodations Needs/Preferences • Center addressed the corrective action for those residents found to have been affected by the deficient practice by the Administrator ordering another sling to accommodate Resident #26 on 9/1/23, sling arrived in facility 9/14/23 and removing interruption of access from personal restroom of Resident #99 on 8/30/23.	9/29/23

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

Electronically Signed | 09/22/2023

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F 558	Continued From page 1 Review of the typed statement signed by the Administrator on facility letterhead, undated, revealed, "(Proper name of facility) does not have an Accommodation of needs Policy." Resident #26 An observation and interview on 08/29/23 at 12:22 PM, revealed Resident #26 lying in bed and stated that sometimes she doesn't get out of bed, because the staff tell her that they only have one sling in the building that will fit her, and it is being used for another resident. An interview on 8/30/23 at 10:55 AM, with Certified Nurse Assistant (CNA) #1 and CNA #2 revealed that Resident #26 required a total lift using a "blue sling", but they were about to use that sling on another resident that had to get up for therapy. They both confirmed there was only one blue sling in the facility, and it must be sent to laundry to be washed between residents. CNAs were asked if they would be able to have the sling laundered in order to get Resident #26 out of bed today and they both confirmed they would not. An interview on 8/30/23 at 11:20 AM, with Laundry Staff #1 revealed that staff usually come to get the slings they need in the mornings and bring them back sometime during the day for them to be washed for the next day. She revealed they would be washed in the afternoon before laundry leaves at 2:00 PM and if not, they will be early in the morning the next day. She confirmed that she does not recall ever being asked to quickly wash a sling in order for the staff to use it on another resident. She revealed she does not know how many blue slings the facility has but there is none currently in laundry to be cleaned.	F 558	• Center identified that all residents have the potential to be affected by the same deficient practice. • To avoid recurrence of the deficient practice, the facility completed 100% audit of all residents in facility on 9/4/23 to ensure all residents have correct sling size available for use. Also, on 8/30/23 facility completed 100% audit to verify all residents have available access to personal restrooms with no negative findings. On 9/1/23 the Administrator, Director of Nursing and Director of Clinical Education initiated an Inservice to all nurses and certified nursing assistants regarding correct sling sizing and access to resident's personal restrooms to be completed by 9/4/23. • The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nurse Supervisors rounding in center three times weekly for four weeks beginning on 9/4/23, two times weekly for four weeks, and weekly times four weeks to ensure proper sling sizing and resident access to personal restroom. Any negative findings will be corrected immediately and addressed with one-on-one in servicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled for the 29th by the interdisciplinary team for review monthly for three months then as	

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F 558	Continued From page 2 An interview and record review on 8/30/23 at 1:46 PM, with the Director of Nurses (DON) revealed she thought the facility had two blue slings, but the resident usually refuses to get up. Record review of Resident #26's most recent lift evaluation revealed a blue sling should be used when transferring the resident out of the bed. An interview on 8/30/23 at 2:30 PM, with Resident #26 with Licensed Practical Nurse (LPN) #2, CNA #1 and CNA #2 present, the resident stated that she would get up out of the bed more, but she wants the correct sling used, and the staff tell her that they only have one and it is being used for another resident. LPN #2, CNA #1, and CNA #2 confirmed that the facility only has one blue sling. An interview on 8/30/23 at 2:45 PM, with Registered Nurse (RN) #1 supervisor confirmed that as far as she knew the facility only had one blue sling. An interview on 8/31/23 at 12:45 PM, with the Administrator confirmed that if they had more than one resident that needed the same size sling then it was probably best to have more than one sling in that size. He stated he had not been made aware that they only had one blue sling in the facility, or he could have already ordered another one. He revealed he understood that they were trying to get the residents that needed the blue sling up on alternate days. Record review of Resident #26's Lift Transfer Evaluation (Hoyer) dated 8/21/23 revealed the resident required a Hoyer Total Lift with an extra-large (XL) sling size which is blue for transfers.	F 558	deemed necessary by the Quality Assurance committee. Date of Completion 9/29/23	

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F 558	Continued From page 3	F 558		

Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 2/29/16 with medical diagnoses that included Unspecified Combined Systolic (Congestive) And Diastolic Congestive Heart Failure and Body Mass Index (BMI) 70 or Greater - Adult.

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/24/23 revealed in "Section C" a Brief Interview for Mental Status (BIMS) Score of 15, which indicated the resident is cognitively intact.

Resident #99

On 08/30/23 at 1:45 PM, an observation and interview in Resident #99's room revealed that there were two red hazardous waste containers stacked inside the bathroom door to the right in the corner in front of the resident's sink. Resident #99 revealed that he has had both legs amputated below the knee and had a hard time transferring onto the toilet when he needed to have a bowel movement. He stated, "I have to lift myself out of the wheelchair, transfer onto the commode and get turned around." He revealed that there wasn't much room in his bathroom and revealed that he could not get to the sink to wash his hands, shave himself or to wash off like he liked to do because of the red containers stacked in there just inside the bathroom door. He said I like to do things myself and don't like to call for help. He revealed that he had asked for the red containers to be removed from the bathroom, but they had not done it yet. It was also observed that a bed-side commode was against the wall with a specimen hat inserted into the top of the

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F 558	Continued From page 4 commode. Resident revealed that he couldn't use that and didn't know why it didn't have the bucket under it like it was supposed to. An interview with 08/30/23 at 2:30 PM, with the Administrator, revealed that he did not know why the red biohazard containers were stored in the bathroom nor who placed them there. He revealed that they should not have been stored in a way that would block the resident's use of his bathroom. Record review of Resident #99's "Admission Record" revealed he was admitted to the facility on 06/13/2023 with the following diagnoses to include: Need for Assistance with Personal Care, Acquired Absence of Right Leg Above Knee, and Acquired Absence of Left Leg Above Knee. Record review of the MDS with an ARD of 06/20/2023 revealed in "Section C", a BIMS score of 09 which indicated Resident #99 had moderate cognitive deficits.	F 558		
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 possible. (i) This includes ensuring that the resident can	F 584		9/29/23

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F 584	Continued From page 5 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 observation, staff and resident interviews and facility policy review, the facility failed to ensure a resident resided in a clean comfortable homelike environment for one (1) of thirty residents reviewed. Resident #99 Findings include: Record review of undated Facility Policy on "5-Step Daily Room Cleaning" revealed ".....the	F 584	F584 – Safe/Clean/Comfortable/Homelike Environment • Center addressed the corrective action for the resident found to have been affected by the deficient practice by the Administrator instructing the Housekeeping Manager to have resident #99's room deep cleaned following the Five Step Patient Room Cleaning	

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F 584	Continued From page 6 proper cleaning method to sanitize a patient room or any area in a healthcare facility." Under "5-Step Patient Room Cleaning Procedure", the facility policy revealed, "1. Empty Trash ... 2. Horizontal Surfaces ... 3. Spot Clean Walls ... 4. Dust Mop ... 5. Damp Mop ..." On 08/29/23 at 3:30 PM, an observation of Resident #99's room revealed sticky brown substance scattered on the floor of his private room, along with trash debris to include napkins, medication cups and gloves. There was also an empty pizza box on the floor lying next to the wall on the left side of his room. It was also observed that there were three urinals open and hanging on the top drawer of the nightstand to the left of Resident's bed. There was 750 milliliters (ml) of amber urine in the first urinal, 350 ml amber urine in the second urinal and the third urinal was empty. On 08/30/23 at 12:05 PM, an observation in Resident #99's room revealed three urinals hanging on the partially opened top drawer of the nightstand. The first urinal closest to the bed held 750 ml of amber urine inside and the second urinal held 350 ml amber urine. An interview at the same time with Certified Nursing Assistant (CNA) #4 as she entered Resident #99's room revealed that the resident was gone for a doctor's appointment. CNA#4 observed the urinals hanging on the nightstand and revealed that she needed to come back in and dispose of the urine. On 08/30/23 at 1:45 PM, an observation and interview with Resident #99 in his room revealed three urinals on the nightstand next to his bed. The first urinal had 900 ml of amber urine and the second had about 350 ml of amber urine inside.	F 584	Procedure on 8/30/23. On 8/30/23 Facility also completed facility wide audit to verify all residents have Safe/Clean/Comfortable/Homelike Environment with no negative findings. • The center identified that all residents have the potential to be affected by the same deficient practice. • To avoid recurrence of the deficient practice, the facility implemented systemic changes that included implementing in the care plan to clean Resident #99's Room two time daily using the Five Step Patient Room Cleaning Procedure. On 9/1/23, the Administrator, Housekeeping Regional Manager, Director of Clinical Education initiated an in-service to all housekeeping staff regarding the Five Step Patient Room Cleaning Procedure and initiated an in-service to all certified nursing assistants regarding the use of walking rounds to inspect all resident rooms and report any that need to be cleaned to the Administrator or the Director of Nursing. • The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nurse Supervisors rounding in center four times weekly for four weeks beginning on 9/4/23, two times weekly for four weeks, and weekly times four weeks to ensure residents have a safe/clean/comfortable/homelike environment any negative findings will be corrected immediately and addressed with one-on-one in servicing and/or the center's progressive discipline policy.	

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F 584	Continued From page 7 This SA also observed a sticky brown substance on the floor throughout resident's room and an empty pizza box on the floor lying next to the wall on the left side of his room. Trash and debris was also noted on the floor of the resident's room to include napkins, medication cups and gloves. The resident revealed that he feels like the staff don't come in very often because of the sign on the door (isolation sign) and that his room had not been cleaned today or yesterday (08/29/23 or 08/30/23). On 08/30/23 at 1:50 PM, the Director of Nursing (DON) entered Resident #99's room with the State Agency (SA) and stated, "This room is disgusting." She also revealed that this room didn't look like it had been cleaned yesterday and had not been cleaned yet today. She confirmed that the CNAs should be making frequent rounds and pouring the urine out of the urinals as soon as he used it. On 08/30/23 at 1:55 PM, an interview with CNA #4, revealed that she had not been in Resident #99's room this morning because he had been gone for a doctor's appointment and stated that the urinals must have been left from the night shift because he was gone this morning and she needed to get back in here and empty them. On 08/30/23 at 2:00 PM, an interview with Housekeeping, revealed that all rooms were cleaned every day and that she cleaned the isolation rooms at the end of the day to help prevent spread of infection. Housekeeping revealed that she normally worked 7:30 AM to 2:30 PM and that she left about 3:20 PM yesterday, 08/29/23. She also revealed that Resident #99's family was in his room visiting	F 584	Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled for the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee. Date of Completion 9/29/23	

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F 584	Continued From page 8	F 584		

while she was trying to clean and sweep the room, so she wasn't in there long yesterday.

On 08/30/23 at 2:10 PM, an interview with the Housekeeping Supervisor, revealed that he teaches the housekeeping staff to clean the isolation rooms last and also revealed that maybe they needed to start getting Resident #99's room cleaned twice a day because stuff seemed to accumulate in his room.

Record review of "(Proper name of cleaning services) Daily Work Routine" form dated 08/29/23 documented that Housekeeper had cleaned Resident Rooms using 5 and 7 Step Method which included to Pull Trash, Horizontal Surfaces, Vertical Surfaces Dust Mop, and Damp Mop. Record review revealed that Housekeeper had marked that these tasks were completed for Resident #99's room on 8/29/23 at 12:00 PM.

Record review of Resident #99's "Admission Record" revealed admit date of 06/13/2023 with the following diagnoses to include: Encounter for Orthopedic Aftercare Following Surgical Amputation, Klebsiella Pneumoniae as The Cause Of Diseases Classified Elsewhere, Pain in Right Leg, Difficulty in Walking, Cognitive Communication Deficit, Need for Assistance with Personal Care, Acquired Absence of Right Leg Above Knee, Acquired Absence of Left Leg Above Knee.

Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/20/2023 revealed under "Section C", a Brief Interview for Mental Status (BIMS) score of 09 which indicated Resident #99 had moderate cognitive deficits.

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F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after	F 645		9/29/23

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F 645	Continued From page 10 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure a resident admitted to the facility had an accurate Pre-Admission Screen (PAS) to ensure the resident was appropriate for nursing home placement for one (1) of two (2) residents reviewed for Pre-Admission Screening and Resident Review (PASARR). Resident #1 Findings include:	F 645	F645 – PASARR Screening for MD & ID • Center addressed the corrective action for the resident found to have been affected by the deficient practice by the Admissions Director submitting information for Preadmission Screening and Resident Review (PASARR) for a re-evaluation for resident #1 on 9/21/23 with residents' new mental health diagnosis. Facility completed an audit of	

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F 645	Continued From page 11 Record review of facility statement on letterhead, undated, revealed, "(Proper name of facility) follows state guidelines for PASSAR." Record review of "Administrative Census" revealed Resident #1 was admitted to the facility for skilled services on 9/9/19 and changed to non-skilled services on 10/19/19. Record review of "PAS Application for Long Term Care" dated 10/14/19, revealed the answer of "no" to the question of "Person has a diagnosis of a major mental illness?" and to the question of "Person has a recent history of a major mental illness?" revealed an answer of "no". Record review of Resident #1's "Admission Record" revealed the resident was admitted to the facility originally on 2/2/2016. The most recent admission date was 5/14/20. Diagnoses included Schizophrenia (2/11/19), Depression (7/26/22), and Dementia (10/1/22). During an interview on 8/31/23 at 8:30 AM, the Social Service Director revealed she was the person responsible for ensuring the accurate completion of the PAS. She confirmed the resident was diagnosed with Schizophrenia on 2/11/19, and on her Pre-Admission Screen dated 10/14/19, this diagnosis was not listed. She confirmed the facility failed to submit an accurate Pre-Admission Screening application with the major mental illness diagnosis of Schizophrenia listed, therefore, the Level II was not done. She stated an accurate screening application is needed to ensure a resident is appropriate for nursing home placement. During an interview on 8/31/23 at 9:45 AM, the	F 645	all current residents Preadmission Screening and Resident Review (PASARR) to ensure that any resident with a new mental health diagnosis(s) had a PASARR evaluation completed, and any mental health diagnosis(s) were identified on the current PASARR screen by 9/21/23 with no negative findings. • The center identified that all residents have the potential to be affected by the same deficient practice. • Administrator provided education to the Social Worker(s) and Admissions Director on the requirements of the Preadmission Screening and Resident Review (PASARR) processing for mental disorders and individuals with intellectual disabilities on 9/15/23. • The Social Worker(s) and Admission Director will audit each resident PASARR Screen at the time of admission beginning 9/15/23 and then weekly thereafter for 10 weeks. Social Worker will report the findings of the audits in the monthly Quality Assurance Performance Improvement (QAPI) Meetings beginning in the September 2023 meeting scheduled for the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee. Date of Completion: 9/29/23	

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	255102	A. BUILDING _____ B. WING _____	08/31/2023

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F 645	Continued From page 12 Director of Nursing (DON) confirmed Resident #1 had a diagnosis of Schizophrenia dated 2/11/19, and on her PAS dated 10/14/19, this diagnosis was not listed. She confirmed that due to the inaccurate application, a Level II was not done, and the screen was to be filled out accurately to ensure the resident is appropriate for nursing home placement and the facility failed to do this. Record review of the Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/5/23, revealed the resident with a Brief Interview for Mental Status (BIMS) score of 11 indicating the resident was mildly cognitively impaired.	F 645		
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).	F 656		9/29/23

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F 656	Continued From page 13 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (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 observations, staff interviews, record review and facility policy review the facility failed to develop and implement comprehensive care plans related to nail care for Resident #61 and #68 and failed to develop a smoking care plan for Resident #77 for three (3) of 33 care plans reviewed. Findings Include: Record review of the facility policy titled, "Comprehensive Care Plan," dated 05/01/12, revealed, " ...Practice Guidelines:1. The	F 656	F656: Develop/Implement Comprehensive Care Plan • The center addressed the corrective action for the residents that could have been affected by the deficient practice of developing and implementing a comprehensive care plan. Concerning residents #61 and #68, care plans related to nail care were updated and orders put in place for nail care to pull to the Routine Treatment Assessment Record to be performed by the treatment registered nurse. Concerning resident #77, a	

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F 656	Continued From page 14 Interdisciplinary care plan is implemented to guide health care center staff in necessary care and services to obtain the highest practicable physical, mental and psychosocial well-being of the resident ...3. Interdisciplinary team communicates mental and psychosocial problems, needs, and concerns to the care planning team for inclusion in the overall plan of care..." Resident #61 On 08/29/23 at 10:29 AM, during an observation and interview, revealed Resident #61 toenails were long and thick, approximately 1/2 " past the end of the resident's toes. An interview with the resident stated that he needs his toenails trimmed. During an interview and observation on 8/30/23 at 1:35 PM, with the Treatment Nurse revealed someone just came and got her to go look at Resident #61's toenails and see if she could trim them. She stated that she had not been told about the resident's toenails needing trimmed before today and confirmed that the toenails were long and needed to be trimmed. An interview on 8/31/23 at 12:52 PM, with the Director of Nurses (DON) confirmed that Resident #61 had a care plan regarding nail care PRN (As Needed), and it was not being implemented. She revealed the purpose of the care plan is to ensure the resident's get their care provided that they need. Record review of Resident #61's care plan revealed "Focus: (Proper name of Resident) has a physical functioning deficit ...Interventions ...	F 656	comprehensive care plan for smoking was put into place at the time the deficiency was discovered. • All residents have the potential to be affected by the deficient practice. • Director of Nursing and Minimum Data Set Nurses completed 100% audit of all care plans to ensure appropriate interventions for smoking and nail care are in the comprehensive care plan. Any negative findings were corrected at the time of discovery. Director of Nursing and Minimum Data Set Nurses completed education with all nursing staff and Interdisciplinary team regarding care plan updates and following plan of care. Education was completed on 09/28/2023. • The Director of nursing and Interdisciplinary Team will monitor smoking evaluations and audit new admissions to ensure smoking interventions and nail care is addressed in the comprehensive care plan. Monitoring will be conducted weekly times 12 weeks beginning 9/4/23. Any negative findings will be corrected immediately and addressed with one-on-one in-service and/or the center’s progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee or until such time compliance is reached. Date of completion: 9/29/23	

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F 656	Continued From page 15	F 656		

Nail Care as needed (PRN) ..."

Record review of Resident # 61's "Admission Record" revealed the resident was admitted to the facility on 11/6/20 with medical diagnoses that included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified

Resident #68

During an observation and interview with Resident # 68 on 08/29/23 at 10:55 AM, revealed excessively long toenails that measured one-half (1/2) inch in length from the tip of the toes on both feet.

An observation and interview with the DON on 8/30/23 at 11:15 AM, confirmed that Resident # 68 had long toenails.

Record review of Resident # 68's care plans revealed" Focus: I have a physical functioning deficit ...Interventions: Nail care PRN (as needed) ..."

An interview with the Minimum Data Set (MDS) Nurse on 8/31/23 at 12:30 PM, revealed that the purpose of the care plan was to identify the resident's needs and goals along with preferences to provide the necessary care. She confirmed that the facility did not follow the care plan for as needed (PRN) nail care for Resident # 68.

An interview on 8/31/23 at 12:45 PM, with Licensed Practical Nurse (LPN) # 4 revealed that the purpose of the care plan was to be able to know everything about the resident to provide the needed care. She confirmed that the facility did

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F 656	Continued From page 16	F 656		

not follow Resident # 68's care plan for as needed nail care.

An interview on 8/31/23 at 12:56 PM, with the Assistant Director of Nurses (ADON) confirmed that Resident # 68's care plan was not followed for nail care.

Record review of the Admission Record revealed Resident # 68 was admitted to the facility on 5/16/22 with medical diagnoses that included Type 2 Diabetes Mellitus and Peripheral Vascular Disease.

Resident #77

During an observation and interview on 08/30/23 at 9:33 AM, observed Resident #77 awake, lying in his bed. Observed a pack of cigarettes and a lighter laying on the bed side table in his room. Resident #77 stated his name and confirmed that those are his cigarettes and lighter and that he goes outside to smoke.

Interview with the Assistant Director of Nursing (ADON) on 08/30/23 at 9:40 AM, confirmed that the cigarettes and lighter should not be in the resident's room and stated, "He is our resident that goes out to the road to smoke and he left yesterday to go out to the store with someone and I bet he bought those cigarettes then. But he usually does keep his cigarettes in his room I think because he smokes independently and goes outside when he wants to." The ADON confirmed that she could see how that could be a safety issue with him keeping his lighter and cigarettes with him in his room. She confirmed that this resident walks across the road to smoke because they are a smoke free facility. He knew

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F 656	Continued From page 17 that when he was admitted so because he is cognitive he said he would just sign himself out on pass and go across the road to smoke, so that is what he does. So, when he does that he just keeps his cigarettes. Record review of the resident's medical record revealed there was not a smoking care developed for Resident #77. Interview with the Director of Nursing (DON) on 08/30/23 at 2:00 PM, stated "Surely he has a care plan, let me check." The DON confirmed at 5:00 PM on 08/30/23 that she had reviewed the resident's medical record and that there was not a smoking care plan for this resident and that when she was looking that they had not completed a smoking assessment on the resident either. She confirmed that a completed smoking assessment would have triggered a care plan to be developed. She stated, "When he first came here he was very sick and has improved, but honestly I didn't know he was a smoker until recently, probably in the last month and we just missed doing a smoking assessment for him and also completing a smoking care plan. Record review revealed that the resident was admitted to the facility on 12/29/22 with diagnoses that included Paranoid Schizophrenia, Heart Failure and Need for Assistance with Personal Care.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		9/29/23

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F 677	Continued From page 18 personal and oral hygiene; 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 provide the necessary nail care for a resident as evidenced by long, thick, overgrown toe nails for two (2) of thirty residents on sample. Resident #61 and Resident #68. Findings Include: Record review of a typed statement on facility letterhead, undated, and signed by the Administrator revealed, "(Formal Name of Facility) does not have a general ADL (Activities of Daily Living) Policy." Record review of a typed statement on facility letterhead and signed by the facility Administrator revealed, "(Formal Name of Facility) adopted Clinical Nursing Skills and Techniques, Perry and Potter as a supplementary policy and procedure care guide. Category: Clinical. Effective Date: Jan (January) 2023" Resident #61 An observation and interview on 08/29/23 at 10:29 AM, revealed Resident #61 toenails were long and thick, approximately 1/2 inch past the end of the resident's toes. An interview with the resident stated that he needs his toenails trimmed. An interview and observation on 8/30/23 at 1:15 PM, with Certified Nurse Assistant (CNA) #5 confirmed that Resident #61's toenails were too long and needed to be trimmed. She stated the	F 677	F677: ADL Care Provided for Dependent Residents • The center addressed the corrective action for the resident that could have been affected by the deficient practice of providing necessary nail care for a resident. Concerning resident #61, nail care was performed at the time of the finding by Registered Treatment Nurse. A follow up visit by the in-house podiatrist was scheduled for 9/11/23. Residents refused to be seen by the Podiatrist. Concerning resident #68, nail care was performed at the time of the finding by Registered Nurse Unit Manager. A follow up visit was also made by the in-house podiatrist on 9/11/23. • All resident's dependent on staff for nail care have the potential to be affected. • Audit completed per Director of Nursing on 09/04/2023 to identify all resident's dependent on staff for nail care. Those residents identified were offered nail care and an appointment with in-house podiatrist on next scheduled visit. All Nursing staff in-serviced by Director of Nursing and Director of Clinical Education on the process of weekly nail audits to be included in the weekly nursing note documentation. Nail care performed at the time of assessment or documented refusal. All Certified Nursing Assistants staff were in-serviced per Director of Nursing and Director of Clinical Education to document condition of nails on shower sheets, nail care performed and/or refusal	

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F 677	Continued From page 19 resident is a diabetic and a Registered Nurse (RN) would be responsible for doing this resident's nails. An interview and observation on 8/30/23 at 1:35 PM, with the Treatment Nurse revealed someone just came and got her to go look at Resident #61's toenails and see if she could trim them. She stated that she had not been told about the resident's toenails needing trimmed before today. She confirmed that Resident #61 toenails were long and needed to be trimmed. An observation revealed the Treatment nurse trimmed the resident's toenails. An interview on 8/30/23 at 1:46 PM, with the Director of Nurses (DON) confirmed that Resident #61 was a diabetic and needed his toenails trimmed. She confirmed that the nurse doing the weekly skin audits should have notified the treatment nurse about the need for nail care. She revealed the treatment nurse, or the RN can trim their nails if they are not too thick, and it should have been done. An interview on 8/31/23 at 12:30 PM, with RN #1 confirmed that Resident #61's toenails were thick and long and that should have been communicated to the treatment nurse to do nail care or she should have done it herself. She stated that any staff member that noticed the resident's toenails are long should notify the RN for nail care on a diabetic resident. She revealed the purpose of nail care is to prevent infection and to prevent them from scratching themselves and diabetics have slow wound healing. Record review of Resident # 61's "Admission Record" revealed the resident was admitted to	F 677	of nail care. This in-servicing was completed on 09/28/2023. • The center plans to monitor the effect of systemic changes to ensure solutions are sustained. All resident's dependent for Activities of Daily Living will be monitored by the Director of Nursing and Assistant Director of Nursing to ensure appropriate nail care is completed and without thick, dirty, or overgrown nails. This monitoring will be completed twice weekly for four weeks, weekly for eight weeks beginning on 08/31/2023 to ensure compliance. Any negative findings will be corrected immediately and addressed with one-on-one education or the center's progressive discipline policy. Findings will be addressed monthly with the Quality Assurance Committee scheduled for September 29th, 2023, with the interdisciplinary team until such time compliance is achieved. Date of completion: 9/29/23	

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F 677	Continued From page 20	F 677		

the facility on 11/6/20 with medical diagnoses that included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified

Record review of Resident #61's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact and in Section G that the resident was totally dependent for bathing.

Resident #68

An observation and interview with Resident # 68 on 08/29/23 at 10:55 AM, revealed excessively long toenails that measured one-half (1/2) inch in length from the tip of the toes on both feet. The resident stated, "The doctor was here a couple of months ago, but didn't cut mine." The resident revealed he was unable to wear socks and was afraid that he may cut himself or someone else.

An observation and interview on 8/30/23 at 11:05 AM, with RN # 1 confirmed that Resident # 68 had long toenails on both feet. She revealed that the treatment nurse was responsible for cutting the resident's toenails because he was a diabetic. She revealed that the Podiatrist just came to the facility a couple of weeks ago, but was unable to see the resident because he had too many residents on the list to be seen. RN #1 confirmed that the resident could scratch or injure himself due to the length of his nails.

An observation and interview with the Director of Nursing (DON) on 8/30/23 at 11:15 AM, confirmed that Resident # 68 had long toenails. She acknowledged that he could potentially

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F 677	Continued From page 21 scratch or cut himself. Record review of the Admission Record revealed Resident # 68 was admitted to the facility on 5/16/22 with medical diagnoses that included Type 2 Diabetes Mellitus and Peripheral Vascular Disease. Record review of the MDS with an ARD of 7/25/23 revealed under section C a BIMS of 15 which indicated Resident # 68 was cognitively intact.	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, staff and resident interview and facility policy review, the facility failed to supervise and complete a smoking assessment for one (1) of three (3) residents who smoked. Resident #77. Findings Include: Record review of facility policy titled, "Safe Smoking," dated 11/01/16, revealed, " Purpose ...2. To assess the ability to smoke and determine any measures needed to protect residents from possible self-inflicted injury during smoking.	F 689	F689 - Free of Accident Hazards/Supervision/Devices • The center addressed the corrective action for the resident that could have been affected by the deficient practice of completing a smoking assessment of a resident. A smoking assessment was performed on resident #77 on 08/30/2023 by Unit Manager. Resident deemed safe to smoke without supervision and has a Brief Interview for Mental Status (BIMS) score of 15. A comprehensive smoking care plan was implemented for resident	9/29/23

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F 689	Continued From page 22 Procedure 1. Any resident who identified themselves as desiring to smoke will be assessed for safety related to smoking. This assessment will be reviewed and updated with any change of condition ..." On 08/30/23 at 9:33 AM, during an observation and interview, observed Resident #77 awake, lying in his bed. Observed a pack of cigarettes and a lighter laying on the bed side table in his room. Resident #77 stated his name and confirmed that those are his cigarettes and lighter and that he goes outside to smoke. An interview with the Assistant Director of Nursing (ADON) on 08/30/23 at 9:40 AM, confirmed that the cigarettes and lighter should not be in the resident's room and stated, "He is our resident that goes out to the road to smoke and he left yesterday to go out to the store with someone and I bet he bought those cigarettes then. But he usually does keep his cigarettes in his room I think because he smokes independently and goes outside whenever he wants to." The ADON confirmed that she could see how that could be a safety issue with him keeping his lighter and cigarettes with him in his room and confirmed that the resident walks across the road to smoke. She stated they are a smoke free facility so he knew that when he was admitted and because he is cognitive she stated that the resident told them that he would just sign himself out on pass and go across the road to smoke, so that is what he does. The ADON revealed, "So, I guess when he does that he just keeps his cigarettes and lighter with him." An interview on 08/30/23 at 2:15 PM, with the Administrator stated, "We are considered a	F 689	#77 on 08/30/2023 by Director of Nursing. The resident was educated by the Director of Nursing on 08/30/2023 regarding signing himself in and out of the facility and returning smoking materials to the nursing staff to be placed in locked storage and staff signing with resident. All nursing staff in serviced on the process of resident #77 signing himself and smoking materials in and out of the facility by the Director of Nursing and Clinical Educator on 8/30/2023. • All residents have the potential to be affected by this deficient practice. • To avoid recurrence of the deficient practice, residents who smoke had their care plans and smoking assessment reviewed by Director of Nursing and Minimum Data Set Nurse on 08/30/2023. Smoking assessments are to be completed in the Clinical Health Evaluation on admission to identify those residents that smoke at home. Education will be provided to resident and family on the center's "Smoke Free" policy. All nursing staff in-serviced on smoking assessments and the center's "Smoke Free" policy by the Director of Nursing and Clinical Educator. Nursing staff education was completed on 09/28/2023. • On going compliance with corrective action will be monitored by the Director of Nursing and Interdisciplinary Team to ensure smoking assessments are completed on admission and included on the comprehensive care plan, beginning on 09/04/2023. Monitoring will be weekly for 4 weeks, 2 times a month for one month then monthly thereafter for a	

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	255102	A. BUILDING _____ B. WING _____	08/31/2023

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DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

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F 689	Continued From page 23 smoke free building, meaning that when new residents are admitted that they know they cannot smoke on the premises and this resident was admitted knowing that he couldn't smoke here on the facility premises so since he is cognitive and alert and signs himself out and walks across the street to be off the premises to smoke." Record review of the resident's medical record revealed there was not a smoking assessment completed for Resident #77. An interview with the Director of Nursing (DON) at 5:00 PM on 08/30/23, confirmed that she had reviewed the residents medical record and that they had not completed a smoking assessment on the resident on admission to the facility. She stated, "When he first came here he was very sick and has improved, but honestly I didn't know he was a smoker until recently, probably in the last month, and we just missed doing a smoking assessment on him. He has a friend that comes by, and he goes out with him and he started bringing back cigarettes and smoking." Record review of the Admission Record revealed that the resident was admitted to the facility on 12/29/22 with diagnoses that included Paranoid Schizophrenia, Heart Failure and Need for Assistance with Personal Care. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 06/29/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is fully cognitively intact.	F 689	minimum of month. Any negative findings will be corrected immediately and addressed with one on one in-servicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 Meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee or until such time compliance is reached as determined by the Quality Assurance Committee. Date of completion: 9/29/23	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		9/29/23

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F 761	Continued From page 24 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to label and date eye drops on one (1) of five (5) medication carts observed during medication administration for C Hall medication cart. Findings Include: Record review of Facility Policy, dated 04/22, titled "Medication Storage, revealed, "It is the policy ...that medication storage complies with	F 761	F761: Label/Store Drugs and Biologicals • The following corrective action was implemented by center to ensure residents were not negatively impacted by this deficient practice of an unlabeled bottle of eye drops, not containing an expiration date. Open bottle of eye drops were immediately discarded and replaced with a new bottle and dated. Audit of all medication carts were completed by the Director of Nursing and Assistant Director	

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F 761	Continued From page 25 state and federal laws and regulations... Expired, contaminated, or deteriorated medications are immediately removed from stock and disposed of according to procedures for medication destruction and reordered from the pharmacy if a current order exists." An observation on 08/30/23 at 8:40 AM, during medication pass with Licensed Practical Nurse (LPN) #5, revealed the eye drops for Resident #10 were not dated on the bottle or box. The date the eye drops were filled from the pharmacy was 05/12/2023. An interview on 08/30/23 at 8:44 AM, with LPN #5 stated that eye drops were good for 60 days before having to be discarded. LPN #5 confirmed that the eye drops had no open date on the box or the bottle and that if the eye drops were filled on 05/12/2023 that they should have been discarded on 07/12/2023. An interview on 08/30/23 at 9:00 AM, with the Director of Nursing (DON) confirmed that eye drops should be discarded 60 days after the fill date and that a date should be placed on the bottle when they are opened.	F 761	to ensure all opened medications had the appropriate labeling of an expiration date. Any unlabeled medications were discarded at time of discovery. Medication cart audit was completed on 08/30/2023. • All residents have the potential to be affected by this deficient practice. • To avoid recurrence of the deficient practice, the facility implemented systemic changes that included in-servicing to the registered Nurses and Licensed Practical Nurses on proper labeling and storage for medications by the Director of Nursing initiated on 9/4/23 and completed on 9/8/23. • The center plans to monitor the performance of the systemic changes to make sure the solutions are sustained by the Director of Nursing, Assistant Director of Nursing, or Registered Nurse Supervisor conducting rounds ensuring all medications on medication carts are dated in accordance with policy daily will be done daily for two weeks beginning 8/31/23, three times weekly times two weeks, then monthly times two months. Any negative findings will be corrected immediately and addressed with one-on-one in-service and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee until such time compliance is reached.	

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F 761	Continued From page 26	F 761	Date of completion: 9/29/23	
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review, the facility failed to label food items in the refrigerator and freezer and failed to maintain a clean ice maker for one (1) of three (3) kitchen tours. Findings Include: Record review of the facility policy titled food storage with an effective date of 11/01/17 revealed under, "Policy: It is the policy of this center to store, prepare and serve food that is	F 812	F812 – Food Procurement, Store/Prepare/Serve-Sanitary • Center addressed the corrective action for those residents found to have been affected by the deficient practice by discarding all food that was not labeled properly in the refrigerator and freezer, center maintenance staff also cleaned and sanitized ice maker located in the kitchen on 8/29/23. • Center identified that all residents have the potential to be affected by the	9/29/23

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F 812	Continued From page 27 stored in accordance with federal, state, and local sanitary codes." Also revealed under, "Policy Interpretation and Implementation... 5. Foods will be labeled as to content and dated ..." Record review of the facility policy titled "Ice Machines" with an effective date of 9/01/14 revealed "Purpose: To maintain dietary refrigeration equipment to preserve food at safe regulated temperatures. The temperatures at which foods are stored can affect their appearance, taste, nutrient content and most importantly their safety... Monthly Preventative Maintenance... Sanitize interior of ice machine per manufacturer's instructions. Clean out and sanitize the ice bin..." Record review of the kitchen ice machine manufacturer's guidelines for cleaning and maintenance revealed under, "1. Cleaning Procedure: 1) Dilute 16 fl. (fluid) oz. (ounce) (473 ml) (milliliters) of Hoshizaki "Scale Away" with 3 gal. (gallon) (11 l) (liters) of warm water." ... Also revealed under, "2. Sanitizing Procedure-Following Cleaning Procedure: 1) Dilute a 5.25% sodium hypochlorite solution (chlorine bleach) with warm water. (Add 1.5 fl. (fluid) oz. (ounce) (44 ml) (milliliters) of sanitizer to 3 gal. (gallons) (11 l)(liters) of water.)..." An observation of the kitchen ice machine with the Dietary Manager (DM) on 8/29/23 at 10:21 AM, revealed a black substance adhering to the inside of the entire ice machine door. The DM confirmed the black substance inside the ice maker door, and she revealed she was not sure what the black substance could be. She revealed that the ice machine was emptied routinely and cleaned by the maintenance department, but she	F 812	same deficient practice. • To avoid recurrence of the deficient practice, the facility implemented systemic changes on 9/4/23 that included the Administrator, and Dietary Manager in servicing all dietary staff on the proper storage and labeling of food as well as changing the cleaning and sanitizing process for facility ice makers from quarterly to bi-monthly. • The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by the Administrator and Director of Nursing, Assistant Director of Nursing, rounding in center kitchen four times weekly for four weeks beginning on 9/4/23, two times weekly for four weeks, and weekly times four weeks, to ensure proper storage and labeling of food and cleanliness of ice maker, all negative findings will be corrected immediately and addressed with one-on-one in servicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee. Date of Completion 9/29/23	

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F 812	Continued From page 28	F 812		

was unsure how often or the last time it was cleaned. She revealed that the black substance could make the residents or staff sick.

An observation of the kitchen stand-up refrigerator with the DM on 8/29/23 at 10:28 AM, confirmed four (4) unlabeled/undated sandwiches wrapped up in clear plastic wrap. The DM revealed the sandwiches were peanut butter, and she revealed she was unsure when they were placed in the refrigerator. An observation of a large clear bag with whitish colored meat that was unlabeled/undated. The DM identified the item in the bag as turkey breast and revealed she was unsure how long it had been in the refrigerator. Observed 12 small burgundy bowls with a whitish/tan chunky substance inside and covered with clear plastic wrap that was unlabeled/undated. The DM revealed the substance was pineapple tidbits and confirmed that the staff should have dated it. The DM confirmed that by not dating the food inside the refrigerator, the staff would not know how long the food had been stored or when it should be thrown away. The DM revealed she was throwing away all the unlabeled foods for safety and acknowledged that the residents could possibly get sick.

An observation of the kitchen freezer with the DM on 8/29/23 at 10:40 AM, revealed an open 32-ounce bag of whole kernel corn with less than one-half (1/2) the bag remaining that was undated. The DM confirmed that the corn should have been labeled when it was opened. The DM also confirmed a clear plastic bag that was opened and undated with six (6) frozen chicken breasts. She confirmed that all things placed inside the freezer should be labeled and dated.

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F 812	Continued From page 29	F 812		

An interview with the DM on 8/30/23 at 1:30 PM, confirmed that the dietary staff had not been cleaning the ice machine and revealed the only cleaning the ice machine received was by the maintenance department.

An interview with the Maintenance Supervisor on 8/30/23 at 1:45 PM, revealed that he did routine cleaning on the ice machine every 3 months. He revealed he cleaned the coils, descaled, delimed, emptied the ice and flushed the ice machine with clean water. He confirmed that he did not clean the inside of the ice machine door as part of his cleaning routine. He confirmed that the kitchen staff were responsible for cleaning the inside of the ice machine door, and he stated, "That should be wiped down daily." He confirmed that the black substance on the inside of the ice maker door could potentially make someone sick.

Record review of the Ice Machine Quarterly Cleaning Schedule revealed the last date of cleaning was documented on 6/14/23.

An interview with the Administrator (ADM) on 8/30/23 at 1:54 PM, with the DM in attendance, confirmed that the Dietary Department was not cleaning the ice machine. The ADM revealed that the black substance that had built up on the inside of the ice machine door could cause staff or residents to become sick.

An interview with the Administrator on 8/30/23 at 2:04 PM, confirmed that all food items placed inside the refrigerator and freezer should be labeled with a date of opening and acknowledged that the residents could become sick from outdated food.

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