DELAWARE HEALTH
AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

263 Chapman Road, Suite 200, Cambridge Bldg
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center Nursing Home

DATE SURVEY COMPLETED: September 24, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual and Complaint Survey was conducted at this facility from September 16, 2024 through September 24, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census on the first day of the survey was eighty-three (83). The survey sample totaled twenty (20) residents. Abbreviations/definitions used in this state report are as follows: CNA – Certified Nursing Assistant; DON – Director of Nursing; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; SW – Social Worker; Tuberculosis (TB) – a serious infectious disease that affects the lungs. TST – Tuberculin Skin Test.	SEAFORD 2567 - September 2024 State Tag State Tag: Pre- employment TB 1. No residents were identified. 2. All residents were at risk by this deficient practice. Current employees' files were reviewed and PPD were administered if indicated. 3. The facility educator was educated by the Administrator on the requirements of PPD. The staff was educated by Administrator or designee on the requirement of PPD. The facility hired a new educator. 4. The scheduler and/or designee will randomly audit five (5) staff members weekly x4 and then monthly x 2. Any negative findings will be reported to the Administrator and audit findings will be taken to QAPI monthly by the Scheduler for review and recommendations. Date Certain is 11/4/2024
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	Scope	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**	

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3201.6.9.2.4	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed September 24, 2024: E 0037, F561, F582, F644, F657, F677, F686, F690, F695, F730, F758 and F812. **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test)...** **This requirement is not met as evidenced by:** Based on interview and review of other facility documentation, it was determined that the facility failed to ensure TB testing was completed timely for three (E4, E5 and E6) out of nine sampled employees receiving TB skin testing when employed. Findings include: Review of a State Agency form entitled Personnel Audit Sheet completed by E12 (RN, IP), revealed three employees did not have their first step of the two-step TST conducted timely (first day in facility / date of TST): 1. E4 (CNA): 5/14/24, 5/16/24. 2. E5 (LPN): 8/6/24, 8/8/24. 3. E6 (SW): 5/6/24, 5/8/24. 9/24/24 10:42 AM – When questioned as to who to interview about the initial TB testing, E1 (NHA) asked to review the Personnel Audit Sheet and stated that no additional interview was needed. E1 confirmed that the facility was out of compliance with TB testing. 9/24/24 2:00 PM – Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.	

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3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** Delaware Food Code 4-802.11 Specifications. (A) LINENS that do not come in direct contact with FOOD shall be laundered between operations if they become wet, sticky, or visibly soiled. (D) Wet wiping cloths shall be laundered daily. This requirement is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure kitchen cloths were maintained in a sanitary manner to prevent food borne illness. 9/16/24 – 10:25 AM – During a tour of the kitchen, a tall plastic basket filled more than half-way with soiled foul smelling wet wiping cloths was located adjacent to the ice machine door. During an interview, E13 stated, "The dirty cloths are stored in the kitchen before being laundered every other day, or so." 9/24/24 2:00 PM – Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.	Sanitation 3201.7.5 1. No residents were identified. 2. All residents were at risk by this deficient practice. Upon identification the rags were disposed of immediately. 3. The kitchen was educated on maintaining kitchen clothes in a sanitary manner to prevent foodborne illness. Manager rounds are being completed 5 days per week. Any areas of concern will be immediately corrected and reported to the Administrator. The root cause was the educational deficit of the staff. 4. The dietary manager will complete the audits weekly x 4 and then monthly x 2. Any negative findings will be reported to the Administrator and audit findings will be taken to QAPI monthly x 2 months by Administrator for review and recommendations. Date Certain is 11/4/2024

Provider's Signature [signature] Title [illegible] Date 10/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from September 16, 2024 through September 24, 2024. The facility census was 83 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were identified.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		11/5/24

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

Electronically Signed | 10/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 037	Continued From page 1 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 2 arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 3 arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

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E 037	Continued From page 4 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined that for two (E10 and E11) out of five (5) staff members sampled, the facility failed to ensure that staff received annual Emergency Preparedness training in the previous twelve months. Findings include: - On 1/10/23, E10 (CNA) received the most recently documented Emergency Preparedness training.	E 037	1. E 1 completed the training on 9/17/2024 and E 2 completed their disaster education on 10/11/2024 2. All residents were at risk with the deficient practice. All CNA□s education has been audited. 3. The staff are being educated by the Educator and or designee on the requirements of mandatory education. The educator has been educated on the	

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E 037	Continued From page 5 - On 3/08/23, E11 (CNA) received the most recently documented Emergency Preparedness training. 9/23/24 - 1:16 PM - Findings were confirmed with E1 (NHA) 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.	E 037	job responsibilities which include the management of the mandatory education. The root cause was the fluctuation in nursing leadership. 4. Facility a new educator started on Sept 30,2024 The Educator and or designee will report the audit weekly x4 and then monthly x 2. Any negative findings will be reported to the Director of Nursing and audit findings will be taken to QAPI monthly by the Director of Nursing for review and recommendations.	
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from September 16, 2024 through September 24, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census the first day of the survey was eighty-three (83). The survey sample totaled twenty (20) residents. Abbreviations/definitions used in this report are as follows: A - Area; ABD - Abdominal; ADON - Assistant Director of Nursing; CM - Centimeter; CNA - Certified Nursing Assistant; DON - Director of Nursing; ID - Intellectual disability; L - Length; LPN - Licensed practical nurse; MD - Medical Director;	F 000		

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F 000	Continued From page 6	F 000		

MDS - Minimum Data Set;
Mg - Milligram;
Ml - Milliliter;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
PRN - as needed;
RC - Related condition,
RN - Registered nurse;
SMI - Serious mental illness;
SW - Social Worker;
UM - Unit Manager;
W - Width.

Abdominal pad dressing - a dressing that is used to absorb discharges from abdominal and other heavily draining wounds;
Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing;
Albuterol Sulfate - medication used to open airways to make it easier to breathe;
AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications;
Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions;
Atrial Fibrillation - irregular and often rapid heart rate that commonly causes poor blood flow to the body;
Braden Scale - tool used to determine risk for development of pressure ulcers;
Brief Interview for Mental Status (BIMS) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15

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F 000	Continued From page 7 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Continence - control of bladder and bowel function; Deep Tissue Injury (DTI) - A type of pressure ulcer that appears purple or maroon and is a localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Eschar - dead tissue that forms a scab-like covering over healthy skin; Exudate - accumulation of fluids in a wound; Heel or ankle boot - A pillow-like boot that covers the entire foot and provides low friction cushioning to the heel; Hypertension - high blood pressure; Incontinence - loss of control of bladder &/or bowel function; Kerlix - a sterile, bulky gauze bandage that can be used as a primary or secondary dressing for wounds; Major Depressive Disorder - also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations; Medication Administration Record (MAR) - list of daily medications to be administered; MediHoney - an antibacterial wound dressing that supports a moist wound healing environment; MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional	F 000		

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F 000	Continued From page 8 capabilities and health needs; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury OR dead; non-viable tissue; Nebulizer - a drug delivery device used to administer medication in a form of a mist inhaled into the lungs; Periwound - the area of tissue around a wound that can be affected by wound-related factors; Preadmission Screening and Resident Review (PASARR) - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Pressure Reduction Device - cushion; Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure; Pressure Ulcer Stage III (3) - A stage of a Pressure ulcer where skin develops an open, sunken hole called a crater. There is damage to the tissue below the skin; Pressure Ulcer Stage IV (4) - A stage of a Pressure ulcer where the ulcer has become so deep that there is damage to the muscle and bone and sometimes to tendons and joints; Psychosis - loss of contact/touch with reality; Quetiapine - an antipsychotic medication that can treat several mental health conditions; Schizophrenia - mental disorder with false beliefs of being harmed; Seropurulent - a type of wound drainage that is	F 000		

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F 000	Continued From page 9 characterized by being watery, thin, and pink in color; Serosanguineous - drainage containing serum and blood; Situation Background Assessment Recommendation (SBAR) - tool used to communicate between members of the health care team; Slough - yellow, tan, gray, green or brown dead tissue; Treatment Adminstration Record (TAR) - list of daily/weekly/monthly treatments to be performed; Unstageable Pressure Ulcer - a stage of a pressure ulcer where the tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); Zyprexa - an antipsychotic medication that can treat several mental health conditions.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		11/5/24

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F 561	Continued From page 10 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R18) out of six residents reviewed for activities of daily living (ADLs), the facility failed to get R18 out of bed in accordance with his preference. Findings include: Review of R18's clinical record revealed: 1/31/24 - R18 was admitted to the facility. 8/8/24 - A quartlerly MDS documented that R18 was dependent for transfer and requires a sit to stand lift for transfer. R18 has a BIMS score of 13 and was cognitively intact. 9/16/24 10:58 AM - An observation of R18 laying in bed watching television. 9/17/24 10:45 AM - An observation of R18 laying in bed watching television.	F 561	1. Resident R- 18 care plan was updated to address his preferences of times of getting out of bed. 2. All residents have the potential to be affected by this alleged deficient practice. Current residents were audited for preferences of time that they would like to get out of bed. Task lists were updated to reflect resident preferences. 3. Education will be completed with all direct care staff by Educator and/or designee on resident rights regarding their preferences. Administrator educated department heads on residents rights which includes preferences. The root cause was the fluctuation in nursing leadership. 4. Unit Managers and/ or designee will interview 10 residents weekly x4 and then	

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F 561	Continued From page 11 9/18/24 1:06 PM - An observation of R18 laying in bed watching television. 9/19/24 12:41 PM - An observation of R18 laying in bed watching television. 9/20/24 9:25 AM - An observation of R18 laying in bed watching television. 9/23/24 12:00 PM - An interview with R18 revealed that his preference is to get out of bed daily. R18 stated that staff tells him they are too busy to get him out of bed. 9/23/24 12:14 PM - An interview with E7 (CNA) confirmed that R18 was not out of bed and confirmed staff is aware of his preference to get out of bed daily. The facility lacked evidence of R18 getting out of bed daily according to his preference. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.	F 561	monthly x 2. Any negative findings will be reported to the Director of Nursing/Administrator and audit findings will be taken to QAPI monthly by the Director of Nursing or designee for review and recommendations.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be	F 582		11/5/24

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F 582	Continued From page 12 charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the	F 582		

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F 582	Continued From page 13 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and interview it was determined that for two (R10 and R48) out of three Medicare Part A discharges reviewed the facility failed to have evidence of a completed Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). Findings include: Review of surveyor requested Skilled Nursing Facility Beneficiary Protection form for three discharged Medicare A residents the following was revealed: 1. R10 started Medicare Part A skilled services on 2/15/24. The last day of covered services was 4/2/24. The resident stayed at the facility as a long-term care resident. There was no evidence the facility provided the SNFABN when Medicare Part A services ended and the resident converted to another payer source. 2. R48 started Medicare Part A skilled services on 4/29/24. The last day of covered services was 7/2/24. The resident stayed at the facility as a long-term care resident. There was no evidence the facility provided the SNFABN when Medicare Part A services ended and the resident converted to another payer source. 9/23/24 2:00 PM - During an interview, E1 (NHA) stated the reason the SNFABN form was not provided to the resident was that the resident was switching to another payer source and the staff did not realize the form still needed to be given. 9/24/24 2:00 PM - Findings were reviewed with	F 582	1. Resident R 10 and R 48 remain in the facility. Unable to have residents sign new Advanced Beneficiary notice (ABN) as policy states Notice must be given at least 2 calendar days prior to the last covered day for Medicare Part A or the 2nd to the last day of service for Medicare Part B and it has been greater than 2 days since the last covered day for Medicare Part A. 2. Residents who meet the criteria for ABN have the potential to be affected by this alleged deficient practice. Minimum Data Set nurse and Business Office Manager audited residents with Medicare residents that transition to long term care in past 30 days for compliance of having the ABN completed. 3. Education to MDS nurse and Business Office Manager, was completed 10/09/2024 by Pod Lead, Market Reimbursement Manager and/or NHA. The root cause was the fluctuation of the MDS personnel. 4. NHA and/or designee will audit weekly x4 and then monthly x2. Any negative findings will be brought to the immediate attention of MDS nurse and/or BOM. Audit findings will be taken to QAPI monthly by the NHA for review and recommendations.	

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F 582	Continued From page 14 E1, E2 (DON) and E3 (Corporate 1) at the exit conference.	F 582		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it has been determined that for one (R64) out of three sampled for PASARR, the facility failed to ensure a referral for a PASARR screening was done for a new mental health diagnosis. Findings include: Review of R64's clinical record revealed: 1/8/23 - R64 was admitted to the facility with the following diagnoses of atrial fibrillation (irregular rapid heart rate), hypertension and major depressive disorder.	F 644	!. Resident R-64 PASRR was updated and submitted on 10/10/2024 for a level 2 PASRR. 2. An audit of the current resident□s PASRR was completed by the Social Service Lead and corrected by the Director of Social Services as appropriate. 3. The Senior Social Services Director and or Administrator will in-service the Admissions Coordinator and the Social	11/5/24

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F 644	Continued From page 15 1/6/23 - Review of R64's PASARR Level I screen outcome documented... "No Level II required.. 2. No SMI (serious mental illness), ID (intellectual disability or RC (related condition)." 12/30/23 - R64's annual MDS (Minimum Data Set) documented a new diagnosis of schizophrenia. 9/23/24 11:50 AM - E6 (SW) was interviewed and stated, "I am not sure if a new PASARR application was done for [R64], I wasn't here then, but I can check. I'm not finding her; I'm searching for her and it's not here. It looks like there was not a new one, but it looks like she is due for a PASARR on 9/22/24, and honestly I am working on it now." 9/24/24 11:40 AM - Findings were reviewed with E1 (NHA). The facility lacked evidence that R64, a resident with a mental disorder, was referred to the state agency for a PASARR Level II evaluation and determination. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.	F 644	Services team on the requirement of correct PASRR and the regulations requiring them to be accurate and timely. The root cause was the fluctuation in Social Service staff. 4. MDS and or designee will complete an audit that PASRR level 2 was completed timely, weekly x4 and then monthly x2. Any negative findings will be brought to the Administrator immediately for follow up. Audit finding will be taken to QAPI on a monthly basis x 2 months for review and recommendations.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		11/5/24

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F 657	Continued From page 16 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R7, R22, R43 and R66) out of twenty (20) sampled residents, the facility failed to ensure that the required interdisciplinary team (IDT) members participated in the care plan meetings and that meetings occurred every three months. In addition, R66's care plan had not been reviewed and revised to reflect a behavior of frequently removing his nebulizer equipment from the protective plastic bag. Findings include: 1. Review of R7's clinical record revealed: 4/10/24 - R7 was admitted to the facility.	F 657	1. Resident R 7, Resident R22, Resident R43 and Resident R-66 still reside in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. Audits were conducted for current residents to determine the last quarterly care plan meeting date. The residents identified as not having a care plan meeting in the last quarter have been scheduled for this week . 3. NHA will determined who is to attend IDT and has educated Department Heads	

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F 657	Continued From page 17 9/19/24 - A review of the notes for the initial care plan meeting on 4/25/24 lacked evidence of input from the Physician. Additionally, there was no evidence that a quarterly care plan meeting occurred in July, 2024. 2. Review of R22's clinical record revealed: 4/10/14 - R22 was admitted to the facility. 9/19/24 - A review of the notes for the care plan meeting on 10/11/23 lacked evidence of input from R22's nurse. A review of the notes for the care plan meeting on 8/14/24 lacked evidence of input from the Physician. Additionally, there was no evidence that there was a care plan meeting from 11/29/23 to 8/14/24 although an OBRA significant change in status assessment was conducted on 2/15/24. 3. Review of R43's clinical record revealed: 7/25/19 - R43 was admitted to the facility. 9/19/24 - A review of the notes for the care plan meeting on 11/22/23 lacked evidence of input from the certified nursing assistant. There was no evidence that there was a care plan meeting from 2/21/24 to 9/11/24, although a quarterly MDS was conducted on 3/16/24 and 6/16/24. Finally, a review of the care plan meeting notes dated 9/11/24 lacked evidence of input from the Physician. 9/24/24 9:59 AM - In an interview, the Surveyor shared the above information with E1 (NHA), who acknowledged that the missing IDT members and gaps in care plan meetings were likely due to staffing issues and turnover.	F 657	who are required to attend and the team will be educated. A weekly list will be sent to the IDT team by Social Services and/or designee of dates and times of said IDT/care conferences. The root cause was the change in Social Service Directors in March 2024. 4. NHA and/or designee will complete a care conference audit and a care conference sign in sheet audit weekly x4 and then monthly x 2. All negative findings will be brought to the immediate attention of the Social Services Director and/or NHA. Audit findings will be taken to QAPI on a monthly basis x 2 months for review and recommendations.	

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F 657	Continued From page 18 4. Cross Refer F695. Review of R66's clinical record revealed: 5/24/23 - R66 was admitted to the facility with the following diagnoses, including, but not limited to, chronic obstructive pulmonary disease (lung disease that blocks air flow and makes it difficult to breathe) and stroke. 8/30/24 - A quarterly MDS (Minimum Data Set) assessment revealed R66 was severely cognitively impaired. 9/18/24 10:31 AM - During an interview, E15 (LPN) stated, "[R66's] nebulizer treatments are ordered to be given every 6 hours as needed." In addition, E15 revealed R66 turns the nebulizer machine on and off himself and R66 takes the nebulizer tubing and mask out of the protective bag himself all the time. Additionally, E15 reviewed R66's care plan for this behavior and stated, "I can't find a care plan for the behavior." 9/18/24 10:54 AM - During an interview, E2 (DON) confirmed she was not aware of E66's behavior of turning the nebulizer machine on and off and removing the nebulizer equipment from the protective plastic bag. E2 confirmed that R66 was not care planned for those behaviors. E2 updated R66's care plan to reflect the behavior. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 and E3 (Corporate 1) at the exit conference.	F 657		
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	F 677		11/5/24

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F 677	Continued From page 19 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 and interview, it was determined that for two (R39 and R89) out of six residents reviewed for ADLs, the facility failed to ensure ADLs were provided to dependent residents. Findings include: A facility policy and procedure titled, "Activities of Daily Living (ADLs) revised 5/1/23 documented ... "Activities of daily living include, hygiene, bathing, dressing, grooming, and oral care." 1. Review of R39's clinical record revealed: 4/12/21 - R39 was admitted to the facility. 8/24/24 - The CNA task list documented R39's shower schedule was on Tuesday and Friday on the 7 AM to 3 PM shift and prefers a bed bath. 9/8/24 - The quarterly MDS documented that R39 was dependent for bathing and personal hygiene. 9/16/24 10:58 AM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/17/24 11:05 AM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/17/24 - A review of the CNA task flow sheet revealed that R39 had a complete bed bath. 9/18/24 2:06 PM - An observation of R39 with	F 677	1. Resident R-39 and R-89 still reside in the facility. 2. Current dependent residents have the potential to be affected by this alleged deficient practice. Current residents were audited to ensure their nails were clean and trimmed and the bed sheets were clean. 3. Director of Nursing and/or designee will conduct an in-service with direct care staff addressing the proper care of nails including resident preferences and high risk conditions. Director of Nursing and/or designee conducted an in-service with certified nursing assistants ensuring that ADLs are provided at the beginning and end of each shift and sheets are changed on shower days and when visibly soiled. The root cause is fluctuation of Nursing Leadership and staff. 4. The Director of Nursing and/or designee will conduct a random audit of resident nails and bed sheets for at least five (5) residents per week x 4 weeks and then monthly x 2. All negative findings will be brought to the attention of the Director of Nursing. Audit findings will be taken to QAPI on a monthly basis x 2 months for review and recommendations. Unit Managers and/or designee will conduct a random audit of at least five (5) residents	

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F 677	Continued From page 20 overgrown finger nails with debris noted underneath. 9/19/24 10:54 AM - An observation of R39 with overgrown finger nails with debris noted underneath. 9/19/24 11:20 AM - An interview with E14 (CNA) revealed that the expectation is that nail trimming to be completed every Wednesday. E14 confirmed nail trimming was not completed and stated she did not have enough time to complete the task. The facility lacked evidence of R39 being provided assistance with ADL care specifically nail trimming. 2. R89's clinical record revealed: 6/4/24 - A quarterly MDS assessment documented [R89] required substantial maximal assist for showering, bathing, oral care, personal hygiene, bed mobility and dependent for toileting . 6/21/24 - R89 was admitted back to the facility from the hospital. 6/23/24 - A five day MDS assessment documented [R89] was dependent for eating, oral hygiene, toileting, showering, bathing, personal hygiene and bed mobility. 6/24/24 - R89 was admitted to hospice care. 6/25/24 - 11:13 AM - Review of R89's facility task sheet documented bathing was provided by E9 (CNA).	F 677	for accuracy of providing ADL care. All negative findings will be brought to the attention of the Director of Nursing. Audit findings will be taken to QAPI on a monthly basis x 2 months for review and recommendations.	

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F 677	Continued From page 21 6/25/24 1:17 PM - Review of R89's facility task skeet documented toileting was provided by E9. 6/25/24 2:30 PM - Review of a facility provided statement from E25 (RN) revealed, "[E9 (CNA)] was assigned to [R89] for care." Additionally, E25's statement also revealed, "[R89] looked disheveled and later that evening [E25] received a call from [E1 (NHA)] regarding [R89's] family's complaint of his appearance during their visit." 6/25/24 9:18 PM - Review of a facility incident report revealed, "there was a concern voiced about [R89's] care." 9/24/24 11:42 AM - During an interview E1 stated, "On 6/25/24, [R89's] family came in to visit and he was disheveled his sheets were not clean, this was around 3:30 PM." E1 also stated, "[R89] was actively dying, he had not eaten, drank, or took any medications in about three to four days." E1 also stated, "[E9] had last seen [R89] at 12:15PM. And that other staff from the 3-11 shift had gone in to immediately clean him up and take care of his needs. Furthermore, E1 confirmed [E9] had been educated on ADL care, abuse, neglect and suspended pending the facility's investigation. The facility failed to ensure that ADLs were provided for a dependent resident. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		11/5/24

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F 686	Continued From page 22 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for two (R20 and R45) out of two residents reviewed for pressure ulcers, the facility failed to provide care and services to prevent pressure ulcers and promote healing. For R45 the facility failed to prevent an avoidable deep tissue injury from developing to the bilateral heels causing harm. For R20 the facility failed to ensure that the resident was turned and repositioned to prevent pressure ulcers resulting in an avoidable Stage 3 pressure ulcer to the right heel and an avoidable stage 4 pressure ulcer to the left heel, resulting in harm. Findings include: A policy titled Skin Integrity and Wound Management updated 5/1/24 documented "a comprehensive initial and ongoing nursing assessment of intrinsic and extrinisic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the	F 686	1.Resident R 20 still resides at the facility. the staff immediately turned and repositioned the resident and floated her heels. R45- still resides in the facility, immediately his heels were floated. He was referred to therapy for positioning. 2. Current residents have the potential to be affected. A skin sweep of current residents was conducted on 9/22/2024. New areas of concern that were identified were addressed and care planned. 3. Nursing staff will be re-educated by the nurse practice educator or designee on potential pressure ulcer contributing risk factors and interventions to put in place if a risk factor is identified. The root cause was staff knowledge deficit on proper use of positioning devices. 4. The director of nursing or designee will audit 5 random residents weekly to	

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F 686	Continued From page 23 comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of case as needed." 1. Review of R20's clincial record revealed: 5/12/22 - R20 was admitted to the facility. 5/12/22 - A careplan for R20 was intiated for dependence of care related to limited mobility. Interventions included to monitor for complications of limited mobility such as pressure ulcers and monitor for decline in ADL function. 7/16/22 - A careplan for R20 was initiated for being at risk for skin breakdown related to limited mobility, incontinence, and fragile skin. Interventions included turn and reposition every two hours, monitor for skin breakdown, and weekly skin check by licensed nurse. The care plan lacked an approach to off load pressure to the heels. 4/2024 - The CNA task flow sheet documented that R20 was to be turned and repositioned and a skin check every two hours. Ten out of ninety-three opportunities were not documented. Twelve out of ninety-three opportunities indicated R20 had reddened areas on skin that did not go away. The facility documentation lacked evidence that staff reported the reddened areas that would not go away for R20 and lacked evidence of implementing any new approaches related to skin breakdown/prevention. 5/2024 - The CNA task flow sheet documented that R20 was to be turned and repositioned and a skin check every two hours. Nine out of	F 686	ensure pressure ulcer prevention and/or interventions are in place and being implemented per the care plan. Wound Care Coordinator will report the results of the initial wound audit, followed by a weekly audit x 4 and then monthly. All negative findings will be brought to the attention of the Director of Nursing. Audit findings will be taken to QAPI on a monthly basis x 2 months for review and recommendations	

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F 686	Continued From page 24 ninety-three opportunities were not documented. Fifteen out of ninety-three opportunities indicated R20 had reddened areas on skin that did not go away. The facility documentation lacked evidence that staff reported the reddened areas that would not go away for R20 and lacked evidence of implementing any new approaches related to skin breakdown/prevention. 5/5/24 - The Annual MDS documented that R20 was dependent for turning, bed mobility, and repositioning with two person physical assist. R20 had range of motion impairments bilaterally of the lower extremities and one side for upper extremities. The MDS assessment also identified R20 was at risk for pressure ulcers/injuries. Despite R20's dependence on staff for bed mobility and impaired range of motion the facility did not update the care plan to include off loading pressure for the heels. 5/19/24 - A nursing Braden scale documented R20 with a score of 17 indicating R20 was at mild risk for skin breakdown. 5/30/24 - An SBAR identified a skin wound or ulcer to R20's left heel which was unstageable. The SBAR lacked evidence of interventions related to care of a pressure ulcer. 5/30/24 - A skin evaluation documented a pressure ulcer was present to R20's left heel and was a in house acquired wound. The pressure ulcer was unstageable related to eschar or slough present. Descripton was noted as 5.9 cm L x 5.0 cm W, no depth, bleeding, serosanguinous exudate, and no odor. The recommendations for treatment were cover with MediHoney, heel	F 686		

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F 686	Continued From page 25 suspension/protection device, turn and reposition. The evaluation stated provider was notified and heel cushion provided. The heel suspension/off loading was not initiated until after the pressure ulcer had developed. 5/31/24 - R20's care plan documented updated interventions to float bilateral heels using a heel up pillow and wound treatments as ordered. 6/11/24 - The SBAR identified a skin wound or ulcer on R20's right heel. The writer E21(RN) documented, "wound bed was moist, malodorous, slough present, and periwound reddened and warm to touch." 6/11/24 - The skin evaluation documented a pressure ulcer was present to R20's right heel and was an in house acquired wound. The pressure ulcer was unstageable related to eschar. Desciption was noted as 3.9 cm L x 4.5 cm W, 12.5 cm A, no depth, moderate exudate, seropurulent drainage, and strong odor. The recommendations for treatment were cover with calcium alginate, foam dressing, and to offload heels. This pressure ulcer occurred after the initial offloading/floating of heels was implemented. 6/13/24 00:00 AM - A wound rounds progress note documented R20 had bilateral heel wounds with necrosis, moist tan slough, no foul wound odor noted , and periwound healthy in appearance. The progress note also documented R20 was educated on wound assessment and plan to continue Medi-Honey covered by dry dressing daily as needed. R20 was also educated on importance of floating heels when in bed to promote healing and reduce further breakdown.	F 686		

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F 686	Continued From page 26 7/18/24 - A wound evaluation documented for R20's left heel wound measurements as 8.63 cm L x 4.38 cm W and 28.85 cm A. The left heel remains unstageable related to slough and eschar. The left heel was noted to have seropurulent exudate and intact wound edges. The treament recommended was cleanse with dakins solution, cover with Medi-Honey, and a clean dry dressing. Continue with heel suspension/protection device and turn/repositioning programm. A review of wound evaluation documented for R20's right heel wound measurements as 3.78 cm L x 3.24 cm W and 9.16 cm A. The right heel remains unstageable related to eschar. The treatment recommended was cleanse with dakins solution, cover with calcium alginate, and a clean dry dressing. Continue with heel suspension/protection device and turning/repositioning schedule. 8/8/24 - A wound evaluation documented for R20's right heel wound measurements as 2.68 cm L x 2.17 cm W and 4.38 cm A. The right heel is now documented as a stage 3 pressure ulcer having serosainguineous exudate with attached edges. The treatment recommended was wet gauze with dakins solution and covered with clean dry dressing. Continue with heel suspension / protection device and turn/repositioning program. 8/15/24 - A wound evaluation documented for R20's left heel wound measurements as 5.56 cm L x 3.85 cm W and 17.26 cm A. The left heel remains unstageable related to eschar and was noted to have bleeding, serosainguineous exudate, and attached edges. The treatment	F 686		

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F 686	Continued From page 27 recommended was wet gauze with dakins solution and covered with clean dry dressing. Continue with heel suspension/protection device and turn/repositioning program. 9/17/24 10:35 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/18/24 10:32 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/19/24 9:10 AM - An observation or R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/19/24 10:31 AM - An observation or R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/19/24 11:26 AM - An interview with E22 (RN) revealed the purpose of floating heels is to prevent skin breakdown and the nurse on duty will verify every shift that the CNA is floating resident's heels while they are in bed. The CNA is expected to check and reposition at least every two hours. 9/20/24 9:24 AM - An observation of R20's bilateral heels resting on mattress with pillow	F 686		

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F 686	Continued From page 28 noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/20/24 10:33 AM - An observation of R20's bilateral heels resting on mattress with pillow noted under calves. The pillow was not positioned correctly for R20's bilateral heels to be suspended off the mattress. 9/20/24 2:09 PM - An interview with E23 (LPN, WCN) revealed the expectation of floating heels is to prevent skin breakdown and/or keep current skin breakdown from worsening. E23 stated that staff should be adjusting pillows for floating heels every two hours or sooner when they go to reposition. E23 confirmed that R20 does not currently have a low air loss mattress at this time and R20's pressure ulcers were in house acquired. 9/24/24 9:48 AM - An interview with E24 (WC, NP) revealed the expectation of floating heels is to prevent skin breakdown and/or keep current skin breakdown from worsening. E24 confirmed that staff should turn and reposition residents at least every two hours and that heels should be floated while residents are in bed. E24 stated R20's bilateral heel wounds were caused by pressure. 2. Review of R45's clinical record revealed: 7/31/19 - R45 was admitted to the facility. 8/18/19 - A care plan for R45 was intiated for dependence of care related to decline in functional ability. Interventions included to monitor for complications of limited mobility such as	F 686		

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F 686	Continued From page 29 pressure ulcers and monitor for decline in ADL function. 8/18/19 - A care plan for R45 was initiated for risk of skin breakdown related to decreased physical mobility and occasional incontinence. Interventions included pat skin when drying and a weekly skin check by a liscensed nurse. The careplan lacked an approach to off load pressure to the heels. 11/10/23 - A nursing Braden scale documented R45 with a score of 19 indicating R45 was at no risk for skin breakdown. 11/10/23 - The quarterly MDS assessment documented that R45 was completely dependent with two physical person assist for bed mobility and turning. R45 had range of motion impairments bilaterally for upper and lower extremities. The MDS assessment also identified R45 was at risk for pressure ulcers/injuries. The MDS indicated that R45 had pressure reducing devices to the bed and chair and did not need a turn/reposition program. The careplan continued to lack approaches to off load pressure from the heels. 12/2023 - The CNA task flow sheet documented that R45 was to be turned and repositioned and a skin check every two hours. Ten out of ninety-three opportunities were not documented. Five out of ninety-three opportunities indicated R45 had reddened areas on skin that did not go away. The facility documentation lacked evidence that staff reported the reddened areas that would not go away for R45 and lacked evidence of implementing any new approaches related to skin breakdown/prevention.	F 686		

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F 686	Continued From page 30 12/20/23 - An SBAR documented that R45 had a DTI (deep tissue injury) to the right heel, unstageable due to sloth or eschar. The SBAR documented the DTI as in house acquired with the following measurements 5.8 cm L x 5.6cm W and 25.7 cm A. The wound was described as a scab, with no exudate, no odor, attached edges, and with dry/flaky calloused surrounding tissue. The treatment recommendations were sure prep, foam mattress, repositioning device(s), and turn/repositioning program. There were no approaches added to off load pressure from the heels. 12/27/23 - A physician's order was completed for a venous doppler study. The study revealed doppler blood flow detected and no indication of thrombus. 12/28/23 - A skin and wound evaluation documented a DTI to the right heel measuring 7.81 cm L x 7.42 cm W, 43.86 cm A, black in color with eschar, attached edges, and dry flaking peri wound. The following interventions were suggested: heel suspension/protection device, low air loss mattress, positioning wedge, and turn/repositioning program. 1/3/24 - An SBAR documented that R45 had four areas noted for DTI. Treatment recommendations were low air loss mattress and to discontinue heel boot to right foot. The record lacked evidence of another form of offloading/floating of heels. 1/13/24 2:15 AM - A skilled evaluation progress note documented a DTI to the right heel with no exudate, odor, tunneling, and fragile periwound.	F 686		

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F 686	Continued From page 31 4/15/24 - A physician's order for a bilateral duplex study was completed. The results recommended a CT study for further evaluation. The results also revealed a positive note for stenosis in multiple arteries. A diagnosis of PVD (peripheral vascular disease) was added to R45's diagnosis list. The facility lacked evidence that a CT study for further evaluation was completed. 4/25/24 - A wound care evaluation documented R45's "right heel with an unstageable pressure ulcer, dry black eschar, with tan moist slough along parameter, mod amount of foul smelling drainage, peri wound is healthy in appearance. Pt consented to debridement of eschar cap, 7mm x 7mm escar cap debrided with scapel down to granulated tissue with tan moist slough, no bleeding noted, no s/s of pain during procedure. Educated patient on wound assessment and of plan to continue dakins moist gauze covered by ABD pad and wrap with Kerlix BID and PRN as well as of importance of at least every two hour turn/repositioning, and of floating his heels when in bed. Patient verbalizes understanding, denies pain with wound assessment." 9/18/24 9:22 AM - An observation of R45 in bed and heels resting directly on the mattress. No pillow noted to float heels. 9/18/24 10:35 AM - An observation of R45 in bed and heels resting directly on the mattress. No pillow noted to float heels. 9/19/24 9:13 AM - An observation of R45 in bed and heels resting directly on mattress and pillow on side of mattress away from feet.	F 686		

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F 686	Continued From page 32 9/19/24 10:30 AM - An observation of R45 laying on back and heels resting directly on mattress. 9/19/24 11:16 AM - An observation of R45 in bed with heels resting directly on mattress. 9/19/24 11:26 AM - An interview with E22 (RN) revealed the purpose of floating heels is to prevent skin breakdown and the nurse on duty will verify every shift that the CNA is floating resident's heels while they are in bed. The CNA is expected to check and reposition at least every two hours. 9/20/24 9:24 AM - An observation of R45's heels laying directly on the mattress. A pillow was placed under legs improperly and the heels are not elevated. 9/20/24 10:36 AM - An observation of R45's heels laying directly on the mattress. A pillow was placed under legs improperly and the heels are not elevated. 9/20/24 2:09 PM - An interview with E23 (LPN WCN) revealed the expectation of floading heels is to prevent skin breakdown and/or keep current skin breakdown from worsening. E23 state that staff should be adjusting pillows for floating heels every two hours or sooner when to go to reposition. E23 confirmed that R45's pressure ulcers were in house acquired 9/24/24 9:48 AM - An interview with E24 (WC NP) confirmed she was working with R45 since April 2024. R45 was sent to wound care and no wound care surgeon would take his case. E24 confirmed she debrided wound to right heel and that R45 was educated on positioning and floating heels.	F 686		

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F 686	Continued From page 33 E24 confirmed that staff was educated on how to use the float devices. E24 stated the expectation for any resident with wounds should be turned and repositioned every two hours, will not wear shoes, and should maintain no pressure from bed. E24 stated that R45's wound reopened this past week and stated lack of floating heels was very likely why the wound reopened. E24 stated any area that has a wound will be weakened and have greater risk to reopen and import to alleviate pressure especially to those areas. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.	F 686		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		11/5/24

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F 690	Continued From page 34 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for three (R20, R38 and R45) out of three residents reviewed for bowel and bladder, the facility failed to respond to or provide services to maintain or restore bladder continence. Findings include: A policy revised on 6/15/22 titled "Continence Management" documented "continence status will be reviewed quarterly as part of the care planning process"..... "to provide appropriate treatment and services for patients with urinary incontinence to restore continence to the extent possible." 1. Review of R20's clinical record revealed: 5/12/22 - R20 was admitted to the facility. 5/5/24 - The Annual MDS assessment documented that R20 was dependent for toileting hygiene and not on a toileting program. The MDS also documented that R20 was frequently incontinent of bowel and bladder.	F 690	1. Residents R20 and R38 both reside in the facility. They have both had their continence status re- assessed. 2. All residents have the potential to be affected by this alleged deficient practice. Current incontinent residents have been reassessed and a bowel and bladder program has been implemented if indicated. 3. Director of Nursing and/or designee will educate licensed nurses on monitoring residents for an increase in incontinence and to use and start voiding patterns for 72 hours in order to initiate a bowel and bladder program where indicated. Root cause is inconsistent Nursing Leadership and staff. 4. Unit Managers and/or designee will randomly audit five (5) residents that have had a decrease in continence weekly x 4 and then monthly x 2. All negative	

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F 690	Continued From page 35 5/2024 - The CNA task sheet documented that R20 was incontinent of urine seventy-three out of eighty-five opportunities. 6/2024 - The CNA task sheet documented that R20 was incontinent of urine seventy-eight out of eighty-four opportunities. 6/12/24 - A skilled evaluation progress note documented that R20 "was incontinent of urine. Resident uses adult briefs. New onset incontinence: No. Resident is frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)." 7/2024 - The CNA task sheet documented that R20 was incontinent of urine eighty-six out of eighty-six opportunities. 8/2024 - The CNA task sheet documented that R20 was incontinent of urine seventy-seven out of eighty opportunities. 8/5/24 - The quarterly MDS assessment documented that R20 was dependent for toileting hygiene and not on a toileting program. The MDS also revealed that R20 was always incontinent of bladder and frequently incontinent of bowel. 9/20/24 10:45 AM - An interview with E7 (CNA) confirmed that R20 is dependent for care and was not on a toileting program. E7 states that R20 does not use a bed pain and is not offered one. 9/20/24 11:30 AM - An interview with E19 (UM) confirmed that the residents bowel and bladder	F 690	findings will be immediately brought to the Director of Nursing. Audit findings will be taken to QAPI on a monthly basis x 2 months for review and recommendations.	

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F 690	Continued From page 36 are assessed upon admission and then quarterly thereafter. E19 confirmed that nurses can intiate a toileting program if they notice a change or decline during the quarterly assessments. E19 confirmed that R20 is not currently on a toileting program. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R20. The facility lacked evidence of a quarterly bowel and bladder assessment for R20. 2. Review of R38's clinical record revealed: 5/10/23 - R38 was admitted to the facility. 9/29/23 - The significant change MDS documented that R38 required extensive two person assist for toileting and hygiene care. R38 was frequently incontinent of urine and always incontinent of bowel. R38 was not on a toileting program. 10/2023 - The CNA task sheet documented that R38 was incontinent of urine fifty-four out of seventy-three opportunities. 11/2023 - The CNA task sheet documented that R38 was incontinent of urine fifty-seven out of eighty-three opportunities. 12/2023 - The CNA task sheet documented that R38 was incontinent of urine seventy-seven out of eighty-nine opportunities. 12/30/23 - The quarterly MDS documented that R38 was dependent for toileting and hygiene care. R38 was always incontinent of bowel and	F 690		

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F 690	Continued From page 37 bladder and not on a toileting plan. 9/16/24 10:49 AM - An interview with R38 confirmed that she used to use a bed pan but has not been using one due to the facility not having a small enough one for her. 9/20/24 11:15 AM - An interview with E20 (CNA) confirmed that R38 is dependent for toileting and hygiene care. E20 also confirmed that R38 did not use a bed pan and was not on a toileting program. 9/20/24 11:30 AM - An interview with E19 (UM) confirmed that R38 was not on a toileting program. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R38. The facility lacked evidence of a quarterly bowel and bladder assessment for R38. 3. Review of R45's clinical record revealed: 7/13/19 - R45 was admitted to the facility. 11/10/23 - The quarterly MDS assessment documented that R45 was dependent for toileting and hygiene care. R45 was frequently incontient of bowel and bladder, and not on a toileting program. 11/2023 - The CNA task sheet documented that R45 was incontinent of urine fifty-two out of eighty opportunities. 12/2023 - The CNA task sheet documented that R45 was incontinent of urine seventy-two out of	F 690		

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F 690	Continued From page 38 eighty-five opportunities. 1/2024 - The CNA task sheet documented that R45 was incontinent of urine eighty-nine out of eighty-nine opportunities. 1/11/24 - The quarterly MDS assessment documented that R45 was dependent for toileting and hygiene care. R45 was always incontient of bowel and bladder and not on a toileting program. 9/20/24 11:15 AM - An interview with E20 (CNA) confirmed that R45 is dependent for care and is currently not on a toileting program. E20 states that R45 does not use a bed pain and is not offered one. 9/20/24 11:30 AM - An interview with E19 (UM) confirmed that R45 was not on a toileting program. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R45. The facility lacked evidence of a quarterly bowel and bladder assessment for R45. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the exit conference.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		11/5/24

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F 695	Continued From page 39 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it has been determined that for one (R66) out of two residents sampled for respiratory care the facility failed to provide professional standards of practice by ensuring R66's nebulizer equipment was stored in a protective plastic bag. Findings include: Cross refer F657 Review of R66's clinical record revealed: 5/24/23 - R66 was admitted to the facility with diagnoses including, but not limited to, chronic obstructive pulmonary disease (lung disease that blocks air flow and makes it difficult to breathe) and stroke. 12/5/23 2:00 PM - A physician's order written for R66 documented... "Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 ml inhale as needed for Shortness of Breath Pre-treatment evaluation in supplemental documentation. In progress note document response to instructions and education and any adverse reactions. Notify the provider of any adverse reactions." 8/30/24 - A quarterly MDS (Minimum Data Set) assessment revealed R66 was severely cognitively impaired. 9/16/24 10:09 AM - R66's nebulizer tubing and	F 695	1. Resident R 66 still resides in the facility. R66 was unable to pass the self-administration assessment. R 66 Care Plan was updated to include residents' desire to self-administer nebulizer treatments and staff to provide education. Immediately completed a house wide audit and replaced all nebulizer equipment and stored them in a protective plastic bag. 2. All residents who have orders for nebulizer equipment have the potential to be affected by this alleged deficient practice. An audit was conducted on current residents to validate that all nebulizer equipment was stored in a protective plastic bag. An audit was conducted for resident's requesting self administration. This audit included included evaluating self administration assessments. 3.The Director of Nursing or designee will educate License nurses on the responsibility of the licensed nurses to provide the professional standard of practice by ensuring that all nebulizer equipment was stored in a protective plastic bag. Licensed nurses will be educated by the nurse practice educator or designee on ensuring that all nebulizer equipment is stored in a protective plastic	

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F 695	Continued From page 40 mask were observed laying on his nightstand table and not placed in a protective plastic bag. 9/17/24 10:00 AM - R66's nebulizer tubing and mask were observed laying on his nightstand table and not placed in a protective plastic bag. 9/18/24 10:41 AM - During an observation and interview, E15 (LPN) stated, "No [R66's] nebulizer equipment is not enclosed in a protective plastic bag. It should be but it's not." 9/18/24 10:54 AM - Findings were confirmed with E2 (DON). 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 and E3 (Corporate 1) at the exit conference.	F 695	bag. Director of Nursing and/or designee will educate licensed staff on assessing those residents who are able and capable to administer nebulizer treatments and document on the self-administration form. The root cause is the fluctuation of Nursing Leadership and staff. 4. Unit Managers and/or designee will randomly audit five (5) residents who have an order for nebulizer treatment to ensure that equipment was stored in a protective plastic bag weekly x 4 and then monthly x 2. Unit Managers and/or designee will randomly audit five (5) residents who are requesting and able to self-administer for accuracy of self-administering and assessment. All negative findings will be immediately brought to the Director of Nursing and/or designee. Audit findings will be taken to QAPI on a monthly basis x 2 months for review and recommendations.	
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five (E7, E8, E9, E10 and E11) out of five certified nursing assistants	F 730	1. No residents were identified. 2. All residents were exposed by this	11/5/24

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F 730	Continued From page 41 reviewed, the facility failed to complete an annual evaluation. Findings include: 9/23/24 approximately 8:50 AM - E1 (NHA) provided documentation regarding CNA evaluations for the following employees: E7 (CNA) with a date of hire of 12/6/22; E8 (CNA) with a date of hire of 5/24/22; E9 (CNA) with a date of hire of 11/20/17; E10 (CNA) with a date of hire of 10/14/19; E11 (CNA) with a date of hire of 3/7/23; 9/23/24 11:59 AM - In an interview, E1 stated that there had been a "system failure" due to turnover with facility staff. The facility was in the process of completing the overdue performance evaluations at the time of the survey. 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.	F 730	deficient practice. Current CNA staff employed at the center have received their annual evaluation as indicated. 3. The Administrator educated nursing leadership on the responsibility of completing annual CNA performance reviews. The root cause was the fluctuation in Nursing Leadership. 4. The scheduler will audit evaluations are completed timely weekly x4 and then monthly x 2. Any negative findings will be reported to the Administrator and audit findings will be taken to QAPI monthly x 2 months by the Director of Nursing for review and recommendations.	
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---	F 758		11/5/24

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F 758	Continued From page 42 §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 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 interview and record review, it was determined that for two (R22 and R57) out of five residents reviewed for unnecessary medications, it was determined that psychoactive medications	F 758	1. Residents R 22 and R 57 still reside in the facility and have had AIMS completed and monitoring for adverse effects added to the behavior monitoring.	

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F 758	Continued From page 43 lacked monitoring. For R22, the facility failed to ensure adequate monitoring with an AIMS assessment. Additonally, the facility failed to monitor R57, a resident taking antipsychotic medication, for symptoms of psychosis. Findings include: A policy and procedure titled "Behaviors: Management of Symptoms" revised 7/1/24 documented... "Patients exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to the patient's behavior. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. 4/10/14 - R22 was admitted to the facility. 8/2023 - R22's MAR reflected that he was ordered Zyprexa (olanzapine) tablet 10 MG Give 0.5 tablet by mouth one time a day. 8/26/23 - An AIMS assessment was conducted. 2/2024 - R22's MAR reflected that he was ordered Zyprexa (olanzapine) tablet 10 MG Give 0.5 tablet by mouth one time a day. 8/2024 - R22's MAR reflected that he was ordered olanzapine Tablet 5 MG Give 2 tablets one time a day. 8/18/24 - An AIMS assessment was conducted. The facility lacked evidence that an AIMS assessment was conducted in February 2024.	F 758	2. All residents who are ordered psychotropic medications are at risk for this alleged deficient practice. Current residents receiving psychotropic medication have been reviewed to ensure an AIMS was completed timely and accurately and monitoring for adverse effects is in place. 3. The Director of Nursing and/or designee will educate licensed staff on monitoring signs of behaviors/adverse effects that could indicate psychosis and updated order to include adverse reactions Director of Nursing and/or designee will educate licensed staff on the policy/procedure regarding AIMS testing. The root cause was the fluctuation in Nursing Leadership and Social Services. 4. Director of Nursing and/or designee will audit new admissions for psychoactive medications for completion of all AIMS assessments and will randomly audit five (5) residents for timeliness of AIMS assessment weekly x4 and then monthly x 2. The Director of Nursing or designee will audit new admissions with a diagnosis of psychosis and ensure that behavior monitoring/adverse effect is in place weekly x 4 and then monthly x 2. Any negative findings will be reported to the Administrator and audit findings will be taken to QAPI monthly x 2 months by Administrator for review and recommendations.	

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F 758	Continued From page 44 9/20/24 approximately 9:50 AM - In an interview, the Surveyor requested a copy of the AIMS assessment that would have occurred between 8/23 and 8/24. E16 (Corporate 2) stated she would check R22's record. E16 stated that this assessment should be done by nursing and should "auto-populate" into the charting system. 9/20/24 10:21 AM - In an interview, E16 stated she would check R22's chart again and acknowledged that R22 had been hospitalized in February, 2024. E16 again stated that the AIMS assessment should "auto-populate." E16 confirmed R22 would have been due for an AIMS in February, 2024. 9/19/24 1:46 PM - In an interview, E17 (NP) stated she was not sure which provider would enter an order for an AIMS assessment, but acknowledged it should be done every 6 months. E17 was not sure why an AIMS assessment was not conducted for R22 between 8/23 and 8/24. E17 stated she would speak with E18 (Medical Director) about who should enter the order. 9/24/24 10:01 AM - In an interview, E1 (NHA) and E3 (Corporate 1) confirmed that an AIMS assessment was not completed for R22 between 8/23 and 8/24. 2. R57's clinical record revealed: 12/1/23 - R57 was admitted to the facility. 1/13/24 - A physician's order for R57 documented ... "Is resident free from side effects of psychotherapeutic medications? (If no, document side effects in PN (Progress Note) every shift."	F 758		

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F 758	Continued From page 45 5/11/24 - A physician's order for R57 documented ... "Quetiapine Fumarate Oral Tablet 25mg give one tablet by mouth one time a day for Psychosis." 9/23/24 1:54 PM - During an interview with E15 (LPN), the surveyor asked if (R57) was monitored for symptoms of psychosis. E15 stated, "Normally it's linked with the medication in the order." E15 reviewed R57's order for quetiapine 25mg and stated, "I don't see anything listed, to monitor for symptoms. There is an order to monitor for side effects on the MAR but not adverse effects." 9/23/24 3:03 PM - E3 (Corporate 1) stated, "There is no documentation of monitoring for symptoms of psychosis for [R57]." 9/24/24 11:40 AM- Findings were reviewed with E1 (NHA). 9/24/24 2:00 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate 1) at the exit conference.	F 758		
F 812 SS=E	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	F 812		11/5/24

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F 812	Continued From page 46 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 and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 9/16/24 - 9:15 AM - During the initial tour of the kitchen, an open plactic bag containing lettuce and celery with browned edges and negative changes in quality and texture was observed in the walk-in refrigerator. 9/17/24 - 8:50 AM - During a tour of the kitchen, a puddle of standing water was observed under the ice machine and the water line that supplies the ice machine. 9/17/24 - 9:25 AM - During a tour of the kitchen, the surveyor observed E13 (Dietary Services Manager) test the sanitizer level of the solution in two red sanitizing buckets. When E13 tested the sanitizing solution, the test strips from each of the buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 9/24/24 2:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate 1) at the	F 812	1. No residents were identified. The leaking pipe was immediately repaired by maintenance and the standing puddle of water was cleaned. The identified food was immediately disposed of. The sanitation bucket was replaced and tested for PH. ECO lab called to calibrate the sanitizing solution equipment. 2. All residents were at risk with this deficient practice. A daily audit will be completed by the Dietary Manager and or designee which includes observations of food procurement, labeling/ dating and sanitation. 3. The dietary staff will be educated by Healthcare Service Regional Team and or designee on food procurement, sanitation and maintaining equipment. Immediate issues will be resolved and reported to the Administrator. 4. The dietary manager will present the audits and trends to the QAPI monthly for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY SEAFORD, DE 19973

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F 812	Continued From page 47 exit conference.	F 812		