DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED: September 26, 2024**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/23/24 - 09/26/24 Survey Census: 82 Sample Size: 23 Supplemental Residents: 7		
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.** **This requirement is not met as evidenced by:**	Cross Refer to the CMS 2567-L survey completed September 26, 2024: E037, F641, F801 and F812.	11/27/2024

Provider's Signature [signature] Title Administrator Date 11/04/24

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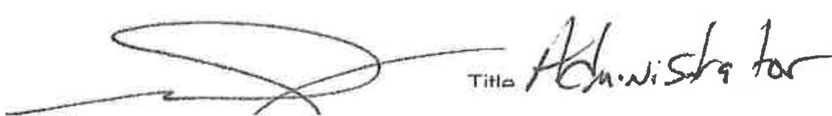
Provider's Signature  Title Administrator Date 11/04/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. BUILDING ______ B. WING ______	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	**101 DELAWARE AVE., DELMAR, DE. 19940-1110 DELMAR, DE 19940**

(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
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 09/23/24-09/26/24. The facility was found not to be in compliance with 42 CFR 483.73.	E 000		
E 037 SS=F	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. (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]	E 037		11/27/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 10/28/2024

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 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 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.	E 037		

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E 037	Continued From page 2 (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 arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 3 (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, 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.	E 037		

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E 037	Continued From page 4 (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 record review and interview, the facility failed to ensure that all staff were trained in emergency preparedness. The failure has the potential to affect all 82 census residents and 119 staff in knowing what to do during an emergency event. Findings include: Review of the emergency preparedness manual on 09/25/24 at 1:30 PM revealed the facility lacked documentation that emergency preparedness training had been completed in the past 12 months. Review of three personnel files which included	E 037	Corrective measures for residents affected: Staff Educator, Director of Maintenance, and Administrator reviewed current education related to emergency preparedness policies and procedures. Educational power points updated to include topics on how to respond to specific emergency situations, emergency evacuation, route, and communication processes with posttest questionnaire to assure staff comprehension (EXHIBIT 1). Education and testing are to be provided to all current staff, all new hires and added to annual emergency preparedness	

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E 037	Continued From page 5 Certified Nurse Aide (CNA) 1, CNA2, and CNA3 related to training revealed no evidence of emergency preparedness training. During an interview on 09/25/24 at 3:00 PM, the Regional Corporate Consultant (RCC) revealed the only annual training conducted included testing for the fire plan and Health Insurance Portability and Accountability Act (HIPAA). She also indicated there was no evidence of emergency preparedness annual training.	E 037	training and updated as necessary. Identification of others with the potential to be affected: Director of Maintenance, Staff Educator, or designee, to assure all 119 current staff and new hires to receive updated emergency preparedness, and annual training. Measures to prevent recurrence: Root cause analysis revealed emergency preparedness and fire plan training and education not completed with all staff consistently upon hire and annually. Documentation to support successful completion of updated orientation packet and annual emergency preparation education checklist column added to existing education tracker for Staff Educator/Compliance Nurse to maintain compliance (EXHIBIT 2). Monitoring of corrective measures: Director of Maintenance, or designee, to monitor whole house staff education related to emergency preparedness with 100% compliance within 2 weeks of POC due date of 11/27/24. Staff Educator, Director of Maintenance, or designee will be responsible for tracking new hire and annual emergency preparedness training monthly to assure compliance (EXHIBIT 3). Audit results to be forwarded to Quality Assurance (QAPI) Committee.	

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F 000	Continued From page 6	F 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/23/24 - 09/26/24 Survey Census: 82 Sample Size: 23 Supplemental Residents: 7	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, the facility failed to ensure residents' Minimum Data Set (MDS) assessments accurately reflected the residents' status for one (Resident (R) 24) of 23 sampled residents. R24's most recent MDS indicated the resident had the serious mental illness (SMI) of bipolar disorder; however, there was not documented evidence in the resident's medical record to confirm the diagnosis. This failure placed the resident at risk for inaccurate and unmet care needs. Findings include: Review of the facility's undated policy titled,	F 641	Corrective measures for residents affected: R24 Resident Assessment Instrument (RAI) Section I: Active Diagnoses modified to remove bipolar disorder diagnosis. MDS coordinator resubmitted R24 RAI to CMS via SimpleLTC portal with acceptance granted on 09/25/24 (EXHIBIT 4). Identification of others with the potential to be affected: MDS Coordinator, or designee, conducted a full house audit for all residents to	11/27/24

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F 641	Continued From page 7 "Comprehensive Interdisciplinary Assessment" revealed "Guidelines: Upon admission and periodically thereafter each resident shall have a comprehensive, accurate, standardized and reproducible assessment of functional capacity and needs ...Procedure: I. The comprehensive assessment for each resident will describe the resident's capability to perform daily life functions and identify significant impairments in functional capacity. The Resident Assessment Instrument process with be completed on all residents per scheduling requirements listed in the Resident Assessment Instrument (RAI) Manual ...V. Each discipline shall complete and electronically sign for the 'completion and accuracy of their entries' in the designated location on the MDS ..." Review of R24's undated "Resident Face Sheet," located in the resident's electronic medical record (EMR) under the "Resident" tab, revealed the resident was admitted to the facility on 09/06/16 and most recently readmitted on 08/13/24 with diagnoses which included major depressive disorder and anxiety disorder. R24's "Resident Face Sheet" did not include the diagnosis of bipolar disorder. Review of R24's untitled Mental Health Progress notes, dated 08/14/24 and located in the resident's hard copy medical record under the "PSYCH" tab, revealed the following documented mental health diagnoses: major depression, anxiety disorder, and adjustment disorder with mixed anxiety and depression. Review of R24's quarterly "MDS" with an Assessment Reference Date (ARD) of 09/10/24 and located in the resident's EMR under the "MDS" tab revealed the facility assessed the	F 641	determine accuracy between MDS assessment diagnoses and SigmaCare Electronic Medical Records (EMR) diagnoses. Audit completed with no further changes identified/required (EXHIBIT 5). Measures to prevent recurrence: Root cause analysis revealed MDS coordinator inaccurately added a serious medical illness diagnosis to R24 RAI upon hospital readmission. Staff educator, or designee, completed education to MDS Coordinator to compare RAI assessment in section I on Admission, Readmission, and quarterly to SigmaCare EMR. Director of Nursing, Staff Educator, Assistant Director of Nursing, or designee, to assure accurate diagnosis/assessments on admission, at quarterly care plans, hospital readmissions and as needed (EXHIBIT 6). Monitoring of corrective measures: Administrator, or designee, will audit assessments weekly X 4 weeks, then monthly X 3 months (EXHIBIT 7). Audit results to be forwarded to Quality Assurance (QAPI) Committee.	

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F 641	Continued From page 8 resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The "MDS" also documented the resident had the active diagnosis of "Bipolar Disorder." During an interview on 09/24/24 at 3:45 PM, R24 stated she had never been diagnosed with bipolar disorder. During an interview on 09/26/24 at 8:53 AM, the MDS Coordinator (MDSC) reviewed R24's quarterly "MDS" with an ARD of 09/10/24 and confirmed the "MDS" indicated R24 had the diagnosis of bipolar disorder. The MSDC stated R24's "MDS" was inaccurate as she double checked the resident's medical record, and the resident had not been diagnosed with bipolar disorder. The MDSC also stated she was the one who completed the resident's "MDS," and she mistakenly selected bipolar disorder as one of the resident's active diagnoses. The MDSC stated it was important the "MDS" be correct to ensure the truest picture of the resident's status. During an interview on 09/26/24 at 9:02 AM, the Director of Nursing (DON) stated it was her expectation R24's "MDS" would have accurately reflected the resident's current diagnoses to ensure the appropriate care was provided. During an interview on 09/26/24 at 9:09 AM, the Administrator stated it was his expectation residents' MDS were accurate to reflect the resident's true current status.	F 641		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		11/27/24

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F 801	Continued From page 9 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801		

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F 801	Continued From page 10 November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.	F 801		

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F 801	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on personnel file review and interview, the facility failed to ensure a qualified Dietary Manager (DM) was in place with appropriate competencies and skills to carryout the functions of the food and nutrition service with the potential to affect all 82 census residents. Findings include: Review of the personnel file on 09/23/24 at 1:00 PM revealed the DM hired in the past five weeks lacked management training for the food service director position. He had 17 years of management experience in food service. The DM had a Serve Safe certificate but lacked management training. During an interview on 09/25/24 at 12:45 PM, the DM revealed he had an associate degree in design and technology with no reference to food service management. During an interview on 09/25/24 at 3:30 PM, the Regional Corporate Consultant (RCC) verified the lack of management training and indicated that the DM would take the test as soon as possible to satisfy the management training requirements.	F 801	Corrective measures for residents affected: Dietary Manager (DM) lacked management training necessary for a food service director position. On 09/26/24, at approximately 10:30 am, DM successfully completed the standards set forth for the ServSafe Protection Manager Certification Examination, accredited by the American National Standards Institute (ANSI), National Accreditation Board (ANAB)-Conference for Food Protection (CFP) certificate number 26274981 (EXHIBIT 11). Identification of others with the potential to be affected: DM required have appropriate competencies and skills including certification in food service management and safety from a national certifying body. Measures to prevent recurrence: Root cause analysis revealed DM held a ServSafe Food Handler Certificate; however, lacked ServSafe Protection Manager Certification. DM completed accredited certification course for management with Staff Educator/Compliance Nurse added DM□s ServSafe Food Handler certification (3) year expiration date and ServSafe Protection Manager certification (5) year expiration date to licensing tracker to	

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	085041	A. BUILDING ______ B. WING ______	C 09/26/2024

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F 801	Continued From page 12	F 801	assure licenses are kept current (EXHIBIT 12). Monitoring of corrective measures: Staff Compliance Nurse/Educator, or designee, to monitor licensure tracker in facility shared folder to assure DM certifications are renewed timely.	
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, interviews, and policy review, the facility failed to ensure the three-pan sink had adequate plumbing, the insulated plate dome covers were in good condition, the kitchen was maintained in a clean manner, and the	F 812	Corrective measures for residents affected: Three-compartment sink found to have inadequate plumbing with water leaking	11/27/24

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F 812	Continued From page 13 sanitizer bucket and three-pan sink had adequate sanitizer levels in accordance with professional standards for food safety. The failure has the potential to contribute to food-borne illness and cross contamination for 82 census residents. Findings include: Review of the facility's undated policy titled, "Dietary Department Sanitizer Guidelines" revealed the three-compartment sink, and other solutions shall be sanitized at 200-400 PPM (parts per million). 1. During observations and interview on 09/24/24 at 9:50 AM, Dietary Aide (DA) 4 was washing dishes in the three-compartment sink. Water was pouring out the plumbing beneath the sink. The plastic water line running below each sink drain ran to a pipe protruding from the floor. Water was pouring out of the pipe onto the kitchen floor near the clean dishes and food. DA4 had to mop the floor to continue working in the area. DA4 was also observed removing rags used as drain stops inside each compartment of the sink, wringing them out and re-inserting them in the drain for the next dishwashing. The facility dishwasher was broken or inoperable. The rinse water was noted to be lacking sanitizer in the third compartment sink. When questioned, the sanitizer was added to the water appropriately. Interview with the Dietary Manager (DM) at the time of the observation indicated the dishwasher was broken causing staff to use the three-compartment sink. During an interview on 09/24/24 at 10:00 AM, the Maintenance Director (MD) revealed staff reported repairs using the Tel's system in the computer. He stated the Tel's computer software	F 812	from drain piping. On 09/24/24, drain plumbing was repaired with sink drain stops purchased and replaced. Water and proper sanitizer/cleaning preparation redone with sufficient levels to provide proper sanitation. On 10/01/24, the dish machine motor arrived and installed with good result. Damaged dome covers for plating discarded and repurchased for replacement. Identification of others with the potential to be affected: DM completed dietary audit for damaged dome lids with current stock identified as not damaged (Exhibit 8). Measures to prevent recurrence: Root cause analysis revealed sanitizer levels required did not adequately reflect 200-400 parts per million (PPM) at three-compartment and within sanitizer cleaning buckets. Department cleaning/ maintenance schedule not maintained sufficiently and timely. Education provided to all dietary staff with cleaning schedules modified to reflect each dietary employee job duties with initial log to maintain accountability. Education provided to dietary staff to drain and replenish sanitation and cleaning solution to appropriate PPM (Parts per million) every 4 hours during open kitchen hours (EXHIBIT 9). Education provided to report all damaged or broken equipment immediately to DM or immediate supervisor to add work order to TELS	

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F 812	Continued From page 14 produced a work order that prompted him to complete the repairs. He stated he did not have a work order for repairs of this pipe in the kitchen under the three-compartment sink. 2. During an observation and interview on 09/24/24 at 9:55 AM, six insulated dome plate covers used in the transportation of food to the units were missing the center knobs exposing the insulation from inside the plastic lid. The knob missing was the size of a Ritz cracker. The lids were stored upside down in the food service area waiting to be used for lunch. The lids with missing knobs were leaking in the upside-down position from the insulation leaving a puddle of dirty water inside of the stored lids. If the lids were used, they would have been turned over to cover the food going to the resident bedrooms, dripping the dirty water from the insulated lids into resident food. Interview with the DM at the time of the observation verified the missing knobs and threw each of the six lids in the garbage can. 3. During observations on 09/24/24 at 10:05 AM, revealed missing, peeling paint under the window opening to the dining room. In addition, a large amount of food splash was observed on the wall near the toaster too numerous to count and red in color. In addition, five overhead pipes which extended the entire length of the kitchen and food service area ceiling, were observed with large amounts of dust and dirt. During an interview on 09/25/24 at 1:30 PM, the DM, Regional Corporate Consultant, (RCC), and Administrator verified the peeling paint and splash. They confirmed there was no cleaning schedule.	F 812	maintenance system for repair/replacement/removal (EXHIBIT 10). Monitoring of corrective measures: DM, or designee, to audit kitchen/dining cleaning and maintenance schedule to assure proper sanitation, operable equipment and staff assigned tasks are completed daily for 5 days then 3 times a week for 3 weeks, and monthly for 3 months until 100% compliance is achieved (EXHIBIT 11). Audit results to be forwarded to Quality Assurance (QAPI) Committee.	

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F 812	Continued From page 15 4. During observation on 09/24/24 at 10:40 AM, Cook (C) 2 used a washcloth that moments earlier were on the wet dirty floor to wash dishes in the two-compartment sink near the stove. She washed the blender used for pureeing meatloaf, carrots, and macaroni and cheese. When finished pureeing each of the three food items, she cleaned the container, blade, and cover without sanitizing either of the items at any time and used the dirty wash rag from the floor. During an interview on 09/24/24 at 11:00 AM, C2 shrugged her shoulders as if to say ok, stating "yes, I washed them." 5. During an observation and interview on 09/24/24 at 10:45 AM, a small red bucket containing a washcloth for wiping off equipment and tables in the kitchen revealed the container lacked the correct amount of sanitizing solution. The test strip used by DA2 revealed 10 PPM. She stated she put sanitizer in the bucket earlier from the sink near the three-compartment sink. 6. During an observation and interview on 09/24/24 at 11:05 AM, DA4 revealed he was washing silverware, pots and pans, insulated dome plate covers by washing, rinsing, and submerging the dishes in the sink, then with the same gloves, removing the clean dishes from the sanitizer and stacking and sorting. Interview with the DM at the time of the observation verified the findings. 7. During observations of 09/24/24 at 11:10 AM, the entrance and exit doors to the kitchen had black stains, missing paint, and a sticky substance on the inside of each door.	F 812		

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F 812	Continued From page 16 During an interview on 09/25/24 at 1:30 PM, the DM, RCC, and Administrator verified the condition of the two doors. They confirmed there was no cleaning schedule. 8. During an observation on 09/24/24 at 11:30 AM, a large metal mouse trap was located on the floor behind the stove. The trap was coated with food debris on the top. Food debris was also located throughout the floor behind the stove in large quantities. During an interview on 09/25/24 at 1:30 PM, the DM, RCC, and Administrator verified the condition of the mouse trap and dirt behind the stove. They confirmed there was no cleaning schedule.	F 812		