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: Excelcare at Newark

DATE SURVEY COMPLETED: February 19, 2025

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: 02/16/25 to 02/19/25 Survey Census: 95 Sample Size: 23 Supplemental Residents:		
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 February 19, 2025: F565, F582, F610, F641, F658, F689, F761 and F812.	Please cross reference 2567 POC submitted on 03/17/2025. Cross Refer to the CMS 2567-L survey completed February 19, 2025: F565, F582, F610, F641, F658, F689, F761 and F812.	

Provider's Signature [signature] Title NHA Date 03/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE AT NEWARK LLC	4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713

(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 An 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 02/16/25 through 02/19/25. The facility was found to be in substantial compliance with 42 CFR 483.73.	E 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: 02/16/25 - 02/19/25 Survey Census: 95 Sample Size: 23 Supplemental Residents:	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		3/31/25

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

Electronically Signed | 03/17/2025

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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F 565	Continued From page 1 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, document review and policy review, the facility failed to act promptly to the concerns and /grievance of the resident council to noise level at shift changes, staff use of phones, earbuds when providing care, and choices offered for breakfast meals for nine of nine (R)60, R4, R21, R37, R14, R39, R5, R73, and R76 sampled residents. This failure could place the residents at risk for decreased quality of life and feelings of hopelessness. Findings include: Review of the facility policy titled "Grievance Program" dated 05/01/2024, documented grievances could be reported verbally or in	F 565	A. 1. R76 no longer receives cranberry juice on her meal trays. 2. The facility is now offering choices for breakfast. 3. The kitchen staff have been in-serviced on sanitation and food quality. 4. The nursing staff have been in-serviced on noise level. B. 1. All residents who file grievances have the potential to be affected. 2. A review of all grievances filed over the past 30 days will be conducted to ensure a written follow-up.	

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F 565	Continued From page 2 writing, and the right to receive prompt efforts by the facility to resolve resident grievances. The actions that should be taken in response to grievances or concerns included, but not limited to, investigation and most practicable resolution, routing the grievance to the appropriate departments for ongoing improvement, identifying trends in care, service delivery, and system organization, and developing long term solutions, implementing changes to improve care/service systems. The policy also stated that a written decision was issued to the person(s) filing the grievance, and to include the collected documentation of grievances in the facility quality improvement program. The policy designated the Social Services Director and/or the Administrator as the key contact responsible to implement the Grievance Procedure, and that the grievances will be logged on the facility grievance log. During an interview on 02/16/25 at 3:15 PM, R76 stated she has had ongoing complaints about the kitchen and had notified staff. The complaints included receiving dirty silverware, cold food, burned food, no yogurt available, burned toast and requesting not to be served cranberry juice but continues to receive it on her tray. During a group meeting on 02/18/25 at 3:30 PM, with nine residents (R)60, R4, R21, R37, R14, R39, R5, R73, and R76, in attendance, they said they had reported excessive noise levels during all shift changes that disrupt their sleep at night and that it is very distracting and intrusive to conversations with family members and other residents. R73 stated, "would give anything for a choice at breakfast" and also stated that she would like to eat in the dining room for breakfast because it gave her the opportunity to get out of	F 565	3. The facility will provide a written follow-up accordingly. C. 1. The Root Cause Analysis (RCA) determined that the facility did not follow its grievance policy. 2. The Staff Developer/designee will re-educate administrative nurses and all departments on the Grievance Policy, including the requirement for a written response. Including a written response will now be emphasized when training on the policy. The Staff Developer/designee will re-educate nurses, C.N.A□s and all other departments on noise level during shift change. Staff are instructed to make change of shifts at nurses□ stations with doors closed during the 3-11 and 11-7 shifts. 3. The NHA/designee will audit all grievances for compliance with the policy, ensuring a written response is provided. D. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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F 565	Continued From page 3 her room and socialize. R76 stated she was not sure why there were no choices for breakfast but quite often does not like what she was given and asks for another option. She said she continues to get cranberry juice even though she has requested not to get it. Review of the electronic medical record (EMR) revealed the following: R60 with a quarterly "Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/20/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 of 15, which indicated R60 was cognitively intact. R4 with a quarterly "MDS" with an ARD of 11/01/24 revealed a "BIMS" score of 15 of 15, which indicated R4 was cognitively intact. R21 with a quarterly "MDS" with an ARD of 11/04/24 revealed a "BIMS" score of 12 of 15, which indicated R21 had moderately impaired cognition. R37 with a quarterly "MDS" with an ARD of 01/10/25 revealed a "BIMS" score of 15 of 15, which indicated R37 was cognitively intact. R14 with an annual "MDS" with an ARD of 01/02/25 revealed a "BIMS" score of 15 of 15, which indicated R14 was cognitively intact. R39 with a quarterly "MDS" with an ARD of 12/13/24 revealed a "BIMS" score of 15 of 15, which indicated R39 was cognitively intact. R5 with a quarterly "MDS" with an ARD of 10/05/24 revealed a "BIMS" score of 12 of 15, which indicated R5 had moderately impaired cognition. R73 with a quarterly "MDS" with an ARD of 11/19/24 revealed a "BIMS" score of 15 of 15, which indicated R73 was cognitively intact. R76 with a quarterly "MDS" with an ARD of 10/10/24 revealed a "BIMS" score of 15 of 15,	F 565		

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F 565	Continued From page 4 which indicated R76 was cognitively intact. Review of "Resident Council Meeting Notes" for 02/2024 through 01/2025 indicated grievances regarding noise level at shift change were reported March 2024, April 2024, May 2024, August 2024, September 2024, October 2024, and November 2024. The grievance regarding no choices offered for breakfast was reported in September 2024 and the grievance regarding cell phone use was reported in September 2024 and November 2024. During an interview on 02/18/25 at 5:42 PM, the Activities Director (AD) stated the dining room was closed because the facility had an outbreak of COVID last year. She stated the dining room was open 10/2024, 11/2024 and 12/2024 but has been shut down except for lunch since the first of the year. The AD stated the reason it continued to be closed is because the facility does not have enough staff. The AD stated that during resident council meetings they have discussed when it would be open, and residents have stated they would like it open. During an interview with the Administrator, Social Service Worker (SSW), and the Staff Development Coordinator, and the Activity Director (AD) on 02/19/25 at 10:36 AM, the Administrator stated that she has not actually tracked patterns and trends of resident grievances. The AD stated that she tracks the concerns/grievances quarterly, then reports the data to the Quality Improvement committee. The Staff Development Coordinator stated sound levels at shift change had not been audited. The AD stated that she has been communicating with a concern form to the Dietary Manager regarding	F 565		

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F 565	Continued From page 5 the grievance requesting a breakfast menu that offered choices. She said she does not follow up with the concern forms and she thought the department managers were supposed to conduct the follow up to the resident council meeting grievances. The AD said she does not follow-up with the grievance or the response to the residents for resolution. The Administrator said she had addressed the grievance voiced by the resident council in June 2024 regarding loud sound levels at shift change. She said she thought the concern had improved and was not aware that the concern was ongoing. She said the resident council grievances had not been addressed since June 2024.	F 565		
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 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	F 582		3/31/25

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F 582	Continued From page 6 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 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, document review and staff interview, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNOC) notification was provided timely for one of three residents (Residents (R) 303) reviewed for beneficiary notification. This had the potential to	F 582	A. 1. The SSW was educated on the need to provide R303 with an ABN. 2. Resident R303 is no longer in the facility B.	

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F 582	Continued From page 7 affect all residents being discharged from services. Findings include: 1. Review of R303's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on 10/09/24 with diagnoses including muscle wasting and atrophy. Review of R303's "SNF Beneficiary Notification Review" form revealed Medicare Part A skilled services start date was 10/09/24 and the last day covered was 11/04/24. Further review revealed no ABN notification was provided prior to the last date of services. During an interview on 02/19/25 at 2:14 PM the Social Service Worker (SSW) stated that she was under the impression that R303 would discharge home on 11/04/24 since that was the resident's initial projected discharge date. She stated due to some back and forth with the daughter the facility became aware on 11/01/24 that the resident would not be discharged from the facility. At that time, an ABN notice should have been provided to the resident and RP, but it was not. During an interview on 02/19/25 at 7:37 PM the Director of Nursing (DON) stated she expected staff to provide the required documentation to residents and their representatives timely.	F 582	1. All residents who require an ABN have the potential to be affected. C. 1. The RCA determined that the SSW did not recognize that R303□s transition from Medicare A to Long-Term Care required an ABN. 2. The Staff Developer/designee will re-educate the Social Worker on the facility□s Medicaid/Medicare Coverage/Liability Notice. Now the facility will review the policy with the Social Service with any changes in the policy. 3. The NHA/designee will audit daily all residents who require an ABN for compliance. D. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		3/31/25

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F 610	Continued From page 8 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to ensure an incident of resident-to-resident abuse was thoroughly investigated for two of five residents (Resident (R)7 and R12) reviewed for abuse out of 23 sample residents. This had the potential to affect residents in the facility who were at risk for abuse. Findings include: 1. Review of R7's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 10/15/21 with diagnoses which included dementia, major depressive disorder, anxiety disorder and bipolar disorder. Review of R7's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/22/24 and located in the EMR under the "MDS" tab revealed a "Brief Interview for	F 610	F610 A. 1. LPN 4 and the ADON was re-educated on the facility□s Freedom from Abuse, Neglect, and Exploitation to include interviewing other residents and staff. B. 1. All residents have the potential to be affected. 2. The facility will review alleged abuses cases investigated over the past 30 days for thoroughness. The facility will obtain statements as indicated. C. 1. The RCA was determined to be	

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F 610	Continued From page 9 Mental Status (BIMS)" score of three out of 15, which indicated the resident was severely cognitively impaired. 2. Review of R12's "Face Sheet" located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on 10/07/22 with diagnoses which included Parkinson's disease, dementia, major depressive disorder, and cognitive communication deficit. Review of R12's quarterly "MDS" with an ARD of 01/11/25 and located in the EMR under the "MDS" tab revealed a "BIMS" score of 11 out of 15, which indicated the resident was moderately cognitively impaired. Review of R12's "Nurse's Note," dated 05/06/24 and located in the EMR under the "Notes" tab, written by Licensed Practical Nurse (LPN) 4 revealed, R12 was in her doorway and staff heard her yell out for R7 to get out of her room, when staff walked to doorway to redirect R7 and R12 said "she kicked me" Review of the facility's "Incident Report/5-day follow-up" dated 05/10/24 revealed on 05/06/24 Nurse heard yelling coming from down the hallway, she observed resident [R7]sitting in her wheelchair in the doorway of resident [R12] nurse approached the room to separate the residents ...Resident [R12]reported that resident [R7] came into her room and accused her of stealing her sweater and when resident [R12] said she did not have her sweater, resident [R7] kicked resident [R12] in the leg ...." Further review of the investigation revealed no evidence of an investigation. The investigation did not contain staff or resident statements.	F 610	that the facility failed to follow their facility□s Freedom from Abuse, Neglect, and Exploitation policy. 2. The Staff Developer/designee will re-educate the staff that conduct facility investigations on the Freedom from Abuse, Neglect, and Exploitation to include interviewing other residents and staff as indicated. Now the investigators will have the policy reviewed annually. 3. The NHA/designee will conduct weekly audits on allegations to monitor for thoroughness to Include interviews from other staff and residents. D. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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F 610	Continued From page 10 During an interview on 02/19/25 at 3:43 PM the Assistant Director of Nursing (ADON) she was the one responsible for completing the resident-to-resident investigation in to the incident that occurred on 05/06/24. As part of the investigation, she would make sure to talk to anyone involved and have them write a statement. The supervisor at the time of the incident would also complete a progress note/risk management. She said whatever documentation was in the file was all that was part of the investigation, and she was unsure why there were no statements by staff or residents and there should have been. She did not know why there was no other documentation in the investigation other than a summary. During an interview on 02/19/25 at 7:37 PM the Director of Nursing (DON) stated that the investigation would include staff and witness statements. The DON stated that she expected that all facility investigations to have been completed thoroughly. Review of the facility's policy titled "Freedom from Abuse, Neglect, and Exploitation" dated 05/01/24 revealed, the facility will investigate different types of incidents and have evidence that all alleged violations are thoroughly investigated.	F 610		
F 641 SS=E	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:	F 641		3/31/25

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F 641	Continued From page 11 Based on record review, interviews, and review Resident Assessment Instrument (RAI) Manual, the facility failed to ensure that three residents (Resident (R) 23, R71, and R153) in the sample of 28 were accurately assessed for falls and one resident (R54) was accurately assessed for insulin. Findings include: Review of the "RAI Manual" dated 10/01/19 indicated, ". . . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set [MDS] items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. . ." 1. Review of R23's "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 02/06/22 with diagnoses that included history of falls, dementia, and chronic obstructive pulmonary disease. Review of the facility's "accident and incident log" dated 2024 revealed that R23 sustained falls on the following dates: 04/14/24 witnessed a fall with injury 04/21/24 unwitnessed fall without injury 05/14/24 unwitnessed fall without injury Review of R23's quarterly "MDS" with an Assessment Reference Date (ARD) 05/15/24 revealed the "MDS" section N did not capture the falls that occurred on 04/14/24, 04/21/24 and 05/14/24.	F 641	F641 A. 1. R23, R71, R153, and R 54. B. 1. All residents that have had a fall and have an MDS due have the potential to be affected. 2. All residents that have insulin have the potential to be affected. C. 1. The RCA was determined to be the MDS Coordinator, was new to this position and could benefit from additional training in coding in these sections. 2. Now the facility will conduct an extended orientation when training new MDS Coordinators with an oversight for CMDSC. 3. The CMDSC/designee will conduct weekly audits of MDS□s that are due for accuracy regarding falls and medications regarding insulin. D. 1. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is	

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F 641	Continued From page 12 2. Review of R71's "Admission Record" located in the resident's EMR under the "Profile" tab revealed the resident was admitted to the facility on 06/14/21 with diagnoses that include dementia, unsteady gait, and major depressive disorder. Review of the facility's "accident and incident log" dated 2024 revealed R71 sustained falls on the following dates: 04/09/24 unwitnessed fall 05/25/24 witnessed fall Review of R71's annual "MDS" with an ARD of 06/12/24 located in the EMR under the "MDS" tab revealed Section N failed to capture the falls the resident sustained during the assessment period. Review of R71's quarterly "MDS" with an ARD of 09/12/24 located in the resident's EMR section titled "MDS" revealed section N failed to capture the falls the resident sustained during this assessment period. 3. Review of R153's "Admission Record" located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on 01/11/24 with diagnosis that include cerebral infarction. Review of the facility's "accident and incident log" dated 2024 revealed the resident sustained falls on the following dates: 08/06/24 witnessed fall 09/16/24 unwitnessed fall Review of R153's quarterly "MDS" with an ARD of 11/18/24 located in the EMR under the "MDS"	F 641	maintained.	

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F 641	Continued From page 13 tab revealed section N of the "MDS" failed to capture the falls that the resident sustained during the assessment period. 4. Review of R54 "Admission Record" located in the EMR under the "Profile" tab revealed the resident was admitted to the facility on 06/23/23 with diagnosis that included diabetes mellitus type II. Review of R54's "Physicians' Orders" dated 05/29/24 located in the EMR under the "Orders" tab revealed the resident was to receive Semglee Subcutaneous Solution 100 units (Insulin Glargine) 17 units at bedtime. Review of R54's annual "MDS" with an ARD of 06/27/24 located in the EMR under the "MDS" tab revealed section N (Medications) of the "MDS" did not reflect the resident received insulin daily at bedtime. Review of R54's quarterly "MDS" with an ARD of 12/28/24 located in the EMR under the "MDS" tab revealed section N (Medications) of the "MDS" did not reflect the resident received insulin at bedtime. Interview on 02/19/25 at 10:44 AM, the Corporate MDS Coordinator (CMDSC) acknowledged that the MDS assessments for R23, R54, R71, and R153 were inaccurate.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		3/31/25

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F 658	Continued From page 14 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility policy, the facility failed to ensure that staff appropriately assessed residents with a change in condition for one Resident (R)153 from a sampled 28 residents. Additionaly staff failed to hold laxatives when the resident was having loose stools. Findings include: Review of facility's policy titled, "Medication Administration" dated 05/01/24 documents " ....Medications are administered under written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse call the provider pharmacy for clarification before the administration of the medication. If necessary, the provider pharmacy contacts the physician for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate ..." Review of R153's "Admission Record" located in the resident's electronic medical records (EMR) section titled "Profile" revealed the resident was admitted to the facility 1/22/24 with diagnoses that included gas gangrene, cerebral infarct, rupture abdominal aortic aneurysm, cognition impairment and unspecified constipation. Review of R153's "Medication Administration Record (MAR)" for December 2024 located in the	F 658	F658 A. 1. R153□s laxative order was clarified to hold for loose stools. 2. LPN 3, LPN 4, LPN 5, LPN 6 and RN 2 were educated on when to get an order to hold laxatives for loose stools. 3. A return demonstration was completed on nurse RN2 B. 1.All residents that have an order for laxatives and loose stools have the potential to affected. 2. All residents with a change in condition have the potential to be affected. 3. A whole house audit was completed for anyone on a routine stool softer, order updated as appropriate. C. 1.The RCA was determined that the facility failed to contact provider for a hold order for the laxative order and change in condition, 2.All residents that have loose stools and are on laxatives have the potential to be affected. 3.Staff Developer/designee will educate licensed nurses on contacting MD provider when there are 3 or more episodes of loose stool. 4. Nurses will be educated on abdominal assessments with a return demonstration. 5.The DON/designee will do weekly audits	

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F 658	Continued From page 15 resident's EMR revealed the resident was started on Senna tablets (laxative) eight point six milligrams daily for constipation on 05/06/24 Review of R153's "Bladder and Bowels Sheets" for December 2024 and January 2025 provided by the facility revealed the resident had loose/watery stools on the following days: 12/2/24 12/3/24 (twice) 12/4/24 (twice) 12/5/24 12/6/24 12/7/24 12/8/24 (twice) 12/9/24 12/11/24 12/15/24 12/17/24 12/18/24 (twice) 12/19/24 12/21/24 (twice) 12/23/24 (twice) 12/24/24 12/25/24 (twice) 12/26/24 12/27/24 12/28/24 (twice) 12/30/24 (twice) 12/31/24 01/02/15 (twice) 01/03/25(twice) 01/04/25 (three times 01/05/25 (twice) 01/06/25 01/07/25 01/08/25 01/09/25	F 658	for hold orders for residents with loose stools for hold orders. 6. The DON/designee will do weekly audits for residents with 3 or more episodes of loose stools for communication to the medical provider, D. 1. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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F 658	Continued From page 16 Review of R153's "MAR" for December 2024 and January 2025 located in the EMR revealed the resident received the Senna laxative on the following dates from the assigned nurses: Licensed Practical Nurse (LPN)4 administered the laxative on 12/06/24, 12/14/24 12/15/24, 12/20/24, 12/24/24, 12/28/24, and 12/29/24. In January, LPN4 administered the laxative on 01/02/25 and 1/03/25. LPN5 administered the laxative on 12/01/24 LPN6 administered the laxative on 12/10/24 Registered Nurse (RN)2 administered the laxative on 12/02/24, 12/03/24, 12/04/24, 12/05/24, 12/07/24, 12/08/24, 12/09/24, 12/11/24, 12/12/24, 12/13/24, 12/16/24, 12/17/24, 12/18/24, 12/19/24, 12/21/24, 12/22/24, 12/25/24, 12/26/24, 12/27/24, 12/30/24 and 12/31/24. January revealed 01/01/25, 01/04/25, 01/05/25, 01/06/25, 01/08/25, and 01/09/25. RN4 administered the laxative on 12/23/24. Review of R153's "Nurses Notes" dated 12/01/24 through 01/09/15 located in the resident's EMR section titled "Progress Notes" revealed no documentation of the resident having loose water/diarrhea stools or notification to the resident's physician or Nurse Practitioner (NP). Review of R153's "Nurses Notes" located in the resident's EMR section titled "Progress Notes" dated 01/09/25 at 5:11PM revealed a note written by the NP that indicated the resident had experienced a change in condition, the resident noted with lethargy, slightly increased respirations, and low blood pressure (BP). Upon assessment, resident is grimacing as if in pain but unable to quantify or describe. Lungs were clear with no abdominal distention. Ordered intravenous fluids (IVF), immediate chest x-ray,	F 658		

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F 658	Continued From page 17 Complete Blood Count (CBC), basic metabolic panel (BMP), and urinalysis (UA) C&S (culture and sensitivity). Resident was straight catheterized, and urine noted to be milky, thick, and malodorous. The resident was later transferred to the emergency room for treatment on 01/09/25 and was hospitalized until 02/15/25. No further information was available as to what caused the residents change of condition. Interview on 2/18/25 at 1:24PM, LPN2 revealed that on 01/09/25, the assigned certified nursing assistant (CNA)2, notified RN2 that R153 was experiencing diarrhea and a change in mental status. LPN2 stated the RN continued to pass medications and did not assess the resident. LPN2 added that RN2 continued to pass medications. LPN2 further stated CNA2 approached RN2 and expressed concern that R153 had a change in condition. LPN2 stated that she went to assess the resident and determined that he had a change in condition. LPN2 instructed RN2 that she needed to assess R153 immediately and notify the NP. LPN2 stated that she had received calls from the NP asking her to reassess residents that RN2 had called her about. LPN2 stated if the resident was having diarrhea for several days, the nurses should not have administered the Senna medication. Interview on 2/18/25 at 2:15PM, CNA2 revealed that on 01/09/25 she informed RN2 that R153 was having loose stools for the past few days and appeared to have a change in mental status. CNA 2 stated RN2 continued to pass medications and did not come to assess the resident. CNA2 stated that she returned to the resident's room to	F 658		

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F 658	Continued From page 18 continue monitoring him. CNA2 stated the resident's condition continued to decline and she again approached RN2 voicing her concerns that the resident's mental status had changed. CNA2 stated RN2 came to the resident's room and looked at him and stated the resident was dehydrated. CNA2 stated RN2 did not perform a physical examination of the resident. CNA2 stated RN2 returned to passing medications. CNA2 stated that she felt the resident needed to be assessed immediately so she notified LPN2 (Charge Nurse) of R153's change in condition. CNA2 stated LPN2 immediately went to assess R153. During an interview with the RN1 on 02/19/25 at 2:20PM, RN1 stated that if the resident had been experiencing loose stools for several days, the Senna medication should not have been given. It was an expectation that RN2 should have immediately assessed R153's condition when the CNA made her aware of the resident's change in condition. Interview on 02/19/25 at 4:20PM, RN2 revealed she remembered the 01/09/25 incident with R153. RN2 stated that CNA2 approached her while she was passing medications about R153 having a change in mental status. RN2 stated CNA2 never informed her the resident had loose stools for several days. RN2 stated she finished passing medications to a resident, then went to assess R153. RN2 stated that she assessed the resident's lung, and bowel sounds, and noticed the resident had low blood pressure. However, RN was unable to explain if she assessed the resident's abdomen for distension or signs of a possible ileus.	F 658		

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F 658	Continued From page 19 Interview on 02/19/25 at 4:40PM with the NP revealed that when she arrived on the unit on 01/09/25 to assess R153 she asked that the resident be straight catheterized. However, the NP stated she did not feel comfortable with RN2 performing the catheterization, so she did the procedure herself. NP stated that she has voiced her concerns about RN2's assessment skills to RN1, and the Director of Nursing (DON). The NP also stated that if the resident was having loose stools/diarrhea and continued to receive the laxative, this could have contributed to his dehydration. Interview on 2/19/25 at 06:00PM, the DON and Administrator revealed they were unaware of any problems with RN2's performance. The DON stated that RN2 had employed less than a year for the evening shift. DON stated RN2 was transferred to the LTC unit 2 months and received additional training for that unit. Both DON and the Administrator stated that they had never been approached by the NP regarding RN2's performance.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 689	F689	3/31/25

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F 689	Continued From page 20 failed to ensure one of one resident (R)72 reviewed for accidents /safety in the sample of 28 revealed that R72 was smoking outside the facility unsupervised, fell and was found on the ground with a bloody nose and swollen, purplish color 5th finger, which was later identified by x-ray as a right hand 5th finger proximal phalanx fracture. Findings include: Review of R72's "Face Sheet" located in electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 03/31/23 with diagnoses which included Chronic Obstructive Pulmonary disease (COPD), acute and chronic respiratory with hypoxia, muscle weakness, cognitive communication deficit, and dependence on supplemental oxygen. Review of R72's Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/14/24 and located in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of 10 out of 15, which indicated moderate cognitive impairment. Review of R72's "Care Plan, dated 10/09/24 and located in the residents' EMR under the "Care Plan" tab revealed, " Potential for safety hazard to self or others as evidenced by non-compliance with prescribed safety measures as evidenced by smoking on facility grounds." Review of the facility's "Incident Report/5-day follow-up" dated 10/22/24 revealed the resident had a fall on 10/18/24, following the fall, the right (R) hand 5th digit was slightly swollen and	F 689	A. 1. R72 is no longer going out unsupervised and the rules were clarified with her regarding where she is allowed to sit B. 1. All residents have the potential to be affected. C. 1. The root cause analysis was determined to be that the facility policy allowed residents sit outside unsupervised. 2. The facility revised policy no longer allows residents to sit outside unsupervised regardless of BIMS score. 3. The Staff Developer/designee will educate all staff across departments on the new policy. 4. The facility will inform residents and POA on the new policy. 5. The NHA/designee will conduct audits for compliance residents sitting outside with supervision. D. 1. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks.	

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F 689	Continued From page 21 purplish in color. She was able to move all digits upon command and denied any difficulty in use of hand/extremity, on 10/20/24 to 10/21/24, the swelling and bruising persisted, and an order was received for a Xray of the R hand. Xray result showed a 5th proximal phalanx fracture. Review of R72's "Physician Orders" dated 08/09/23 and located in the EMR under the "Orders" tab revealed oxygen at 3 liters per minute (LPM) via nasal cannula. Review of "Progress Note" dated 10/18/24 at 1:07 PM written by Registered Nurse (RN)1 revealed resident found outside by another resident who notified nursing. The resident was bending and leaning forward to pick up her glasses and fell forward. Resident noted with a bloody nose and a skin tear to right upper eyelid. Nurse Practitioner (NP) notified. Resident safely brought back inside facility and vitals obtained. Review of "Radiology Results Report" dated 10/21/24 located in the residents EMR under the "Misc" tab revealed reason acute pain due to trauma. Further review revealed 5th proximal phalanx fracture with mild displacement. During an interview on 02/17/25 at 4:16 PM R72 stated that on 10/18/24 she went out the front door and that nobody told her she could not go outside. She was out there about 30 minutes, but she was not sure if she was supposed to let anyone know. She said she smoked at the time and had a cigarette and lighter with her. She did not know she was not supposed to smoke at the time. She said she took her nasal cannula off and hung it on the back of her wheelchair. She said she took precautions. She fell out of the seat and	F 689	3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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	085025	A. BUILDING _____ B. WING _____	C 02/19/2025

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F 689	Continued From page 22	F 689		

hit her face on the ground and her arm and hand were sore. She stated she broke one of her fingers. She is not allowed to go outside without staff now, but she was unsure of what the rules were. But she thinks she can still go outside and sit by the bench.

During an interview on 02/18/25 at 11:56 AM, RN1 stated that residents who had a BIMS of 12 or higher and were their own responsible person used to be allowed to go outside in front of the facility and hang out on the front porch. But they were not allowed to go to any other area on the facility grounds. They were supposed to make their assigned nurse aware and let the receptionist know. The receptionist was supposed to verify with their nurse if they were allowed to go outside. She said there was no structured process to monitor/supervise residents s while they were outside. She said the facility was a nonsmoking facility. R72 was a smoker prior to being admitted but she was unaware of any time that R72 had attempted to smoke on facility grounds or had smoking materials in her possession. On 10/18/24 another resident (unsure who) was coming back into the facility and notified staff up front (unsure who) that R72 was on the ground. She notified the Assistant Director of Nursing (ADON), the Director of Nursing (DON) and one of the unit managers. She said they all went outside and found the R72 out front by the flagpole near a bench . This was an area that residents were not supposed to be because you were unable to see them from the front door due to bush blocking the front of the bench. She said R72 was sitting up on the grass and her nose was bleeding and she had a skin tear on her eyebrow. She told staff she wanted to come outside and have a moment to herself

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F 689	Continued From page 23 somewhere quiet. She was unsure if R72 told her nurse she was going outside. She was not sure if there was a change to R72's plan of care. There was an Interdisciplinary Team (IDT) meeting, but she was unsure what was changed. But she assumed R72 would require supervision after that. When asked about the care plan intervention on 10/09/24 that was initiated by her regarding R72 being noncompliant with smoking. she said, "I forgot" about that. But she was unsure what had occurred to require that change in the resident's care plan. She said she thinks R72 may have had a lighter in her room and that R72 had been caught smoking outside before. But she did not know any specifics. She was unsure what if anything was done to ensure R72 did not have smoking materials or that she was supervised when she went outside. She thinks they took the lighter away from R72 but can't remember. She said she did not remember seeing anything outside on 10/18/24 that suggested R72 was smoking before she was found on the ground. During an interview on 02/18/25 at 12:22 PM, Licensed Practical Nurse (LPN)1 said in the past residents who had been deemed mentally competent and physically safe to be outside were allowed. But she was unsure how that was decided. She said she would have to ask which residents were allowed to go outside. She was also unsure how or who was responsible for monitoring the residents while they were outside. She is not sure if residents are still allowed outside but she is not aware of any specific residents that can and do go outside without staff supervision. R72 was allowed to go outside without supervision but she is no longer able to without supervision because R72 had a fall	F 689		

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F 689	Continued From page 24 outside. She said she was R72's assigned nurse that day on 10/18/24 but she did not see the actual fall, but was told R72 was outside on the ground. She said the R72 did not let her know she was going outside. She said R72 was found behind the bush by the bench next to the flagpole. She said R72 was hiding behind the bush because she was smoking, and she knew she was not supposed to be. She stated that she, along with the DON, ADON, and RN1 went out there. R72 was sitting on her bottom in front of her wheelchair and there was a lit cigarette right by R72 on the ground that was almost a burnt to the butt. She was unsure where the lighter was. She asked the R72 why she was out there and at first she lied but then admitted that she just had "a couple of puffs." She was unsure if she was sitting in the wheelchair that had the oxygen tank on the back or on the bench while she was smoking but she did see the nasal cannula hanging over the back of the chair/tank. She said the nasal cannula was not on her face. She said she was unsure if anyone asked R72 about the fact that she was smoking close to her oxygen tank. After that she was not allowed to go outside unassisted without staff anymore. She said staff were not allowed to let any residents outside. During an interview on 02/18/25 at 4:36 PM, the ADON said residents were allowed to go outside who had a BIMS score higher than a 12 or 13 and were not an elopement risk or exit seeking. She said there was no formal process to monitor residents while there was outside but there was an expectation that any staff going by should look for them. The receptionist or another staff at the front desk would have to put in the code for the front door to open. She said the staff at the front desk would usually call the nurses station to see	F 689		

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F 689	Continued From page 25 if the resident was allowed to go outside. There was no set time for how long they could be out there, but they did consider things like weather. She said staff had observed R72 smoking when she was not supposed to be, and it was more than once. But she was unsure what was put into place besides educating her and the family member about nonsmoking and with her oxygen near. On 10/18/24 she said R72 was outside, down by the park bench, and had reached to pick up her glasses and fell. She said the staff asked her if she was smoking and she said no and there were no smoking materials around. During an interview on 02/18/25 at 5:01 PM the former receptionist said when residents wanted to go outside she would ask the Activity's Director if they were allowed and would let her know when a resident went outside and that the Activity's Director or the assistant would periodically monitor them. She said residents were not allowed to go to the bench by the flagpole because it was too far for staff to see. R72 had been warned several times about being outside smoking. On 10/18/24 she said she notified the Activity's Director when R72 went outside. She said when she was found R72 she was on the ground, and she was covered by some bushes. She said that was exactly why R72 went out behind the bushes because she was hiding to smoke because she had an oxygen tank, and she knew she wasn't supposed to smoke with it. She said the person who reported seeing the resident on the ground reported that she was out there smoking. She was unable to remember who that person was. But she was unsure how long R72 had been out there before she was observed on the ground. She was unsure if anyone had checked on her before she was found.	F 689		

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F 689	Continued From page 26 During an interview on 02/18/25 at 5:20 PM, the Activity's Director said residents that were deemed alert and oriented and were safe to be outside were allowed to be outside without staff supervision. She said staff would keep an eye on them every 15 to 20 minutes. But residents had to remain in the front door area. She said on 10/18/24 she could not remember anyone telling her that R72 went outside and that she did not go outside to check on her during that time. During an interview on 02/19/25 at 4:27 PM the DON stated that on 10/18/24 she was in the office and heard the receptionist yell out. She ran outside along with other staff and observed R72 on the ground. She did not remember seeing any smoking materials. There was history of R72 being non-compliant with smoking after staff had seen her with a cigarette and a vape and that she was on continuous oxygen. She said residents with a BIMS score of 13 and up were allowed to go outside and sit out there during the summer months without staff. She said the Activities Director, or the Activities staff would check them periodically. She said when residents were outside that she expected staff would monitor them and she was unaware that no staff were monitoring R72 on 10/18/24. She also stated that since R72's BIMS prior to 10/18/24 was only a 10 and it was under 13 than R72 should not have been allowed to go outside. She said at that time there was not really a process in place to monitor residents at that time. But that after R72's first noncompliance with smoking in August 2024 and her low BIMS score, she should not have been allowed outside on 10/18/24.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		3/31/25

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F 761	Continued From page 27 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure that expired medications and syringes were removed from one of one medication storage room. The failure has the potential for staff to inadvertently use the expired items. Findings include: Review of the facility's policy titled "Storage of	F 761	A. 1. All expired medications and syringes were thrown away. B. 1. All residents that have Imipenem Hydrochloride ordered and residents that need have medications administered through a syringe the potential to be	

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F 761	Continued From page 28 Medications" dated 05/01/24 indicated, " ...Drug containers that have missing, incomplete, improper, or incorrect, labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biological are returned to the dispensing pharmacy or destroyed ..." Observation of the facility's main medication storage room next to the nurses' station on 02/17/25 at 1:17 PM revealed the following concerns: Six of six Magellan three-centimeter (cc) syringes with hypodermic need safety needle 23 gauge one inch with an expiration date of 07/31/21 The facility's Intravenous (IV) tray contained the following expired items: one bottle of Imipenem Hydrochloride (synthetic antibiotic) 500 milligrams (undiluted) with an expiration date of 10/24 Six female luer lock caps (used to prevent leakage) with the following expiration dates 03/26/24 (two syringes); 03/27/24 (one syringe); 05/07/24 (two syringes; and 05/08/24 (one syringe) One Braun Fluid Dispenser for filling dose syringe from large size syringe with expiration date 12/31/23 Interview on 02/17/25 at 02:10 PM, the Floor Supervisor Licensed Practical Nurse (LPN)2 confirmed the observations and stated that Central Supply was responsible for checking the medication storage for expired items.	F 761	affected. 2. The facility will conduct a whole house audit medication room to look for expired medications and syringes. Medication and syringes will be thrown away accordingly, C. 1. The RCA determined that routine audits of the medication room for expired medications were not being audited. 2. Now the Unit Managers will conduct weekly audits of the medication room for expired medications. 3. The Staff Developer/designee will train Unit Managers on the new checklist for the medication room. 4. The DON/designee will conduct weekly audits of the Medication Room for expired medications and expired. D. 1. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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F 812	Continued From page 29	F 812		
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 facility policy review, the facility failed to ensure containers with rice and pasta were labeled, dated and cleaned; the inside and outside of the oven and microwave were not clean and grease/debris on the handles; the floor under the three-tiered rack had grease and debris; and during meal service the chicken and mixed vegetables were not served at the appropriate temperature on the steam table. This deficient practice had the potential to affect 95 of 95 residents who received meals prepared in the facility. This failure had the potential to affect the spread of food borne illness.	F 812	F812 A. 1. Plastic containers were cleaned. 2. Rice container has been dated. 3. The Elbow Macaroni and spaghetti was thrown away. 4. The area by the three-tiered rack has been cleaned. 5. The microwave and doors of the oven were cleaned. B. 1. All residents have the potential to be affected.	3/31/25

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F 812	Continued From page 30 Findings include: Review of the undated facility policy titled, "Equipment Cleaning Policy" provided by the facility indicated, "The director of Dining Services or designee will ensure that all equipment is maintained, kept clean and in a sanitary condition before and after each use...Conventional/Convection Ovens: Clean after each use, inside and out, using soap and water ...Microwave: Clean after each use, inside and out, using soap and water." Review of the undated facility policy titled, "Hot Food Policy" provided by the facility indicated, "Hot food should be at 135 degrees or above at the time food is served to the residents." During the initial kitchen tour on 02/16/25 at 9:20 AM with the Cook (CK1), the following observations were made: 1. In the dry goods pantry there were three large plastic containers that had a visible powder substance on the inside and crumbs on the top. The lids were visibly dirty and had a gritty feel to them. One container contained approximately 2" of loose rice and did not have a date. One container has approximately ½" loose elbow macaroni and a bag sitting on top of the macaroni dated 2/11. CK1 was uncertain if the date on the bag was the date the bag was opened. The third container had loose spaghetti with a sticker that read 11/02/24. CK1 said they usually keep pasta for thirty days. 2. In the prep area in the kitchen there was a three-tiered rack that held pots and pans. On the floor was a black mat. There was grease on the	F 812	C. 1. The RCA was determined to be that the facility did not follow their kitchen sanitation checklist and the cook needed re-education on the facility□s Hot Food Policy. 2. The Staff Developer/designee will re-educate dietary staff on the sanitation checklist. 3. Now the sanitation checklist and food temperature will be reviewed weekly with the NHA, 4. The facility revised the Hot Food Policy to state that food must reach a temperature of 135 Degrees before being placed on the steam table. 5. The Staff Developer/designee will re-educate the cooks on the revised Hot Food Policy. 6. Weekly he FSD/Designee will audit compliance to the kitchen inspections checklist and audit tray-line temperatures for compliance. D. 1. The facility will conduct audits as follows: 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is	

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F 812	Continued From page 31 floor, crumbs, and scraps of paper. 3. The door handles of each side of the oven and the door handle of the microwave was covered in a thick greasy substance and food particles. During the second kitchen tour on 02/17/25 at 4:00 PM with the Dietary Manager (DM), the following observations were made: 1. In the dry goods pantry, there were three large plastic containers that continued to have visible powder substance on the inside and crumbs and the lids were visibly dirty and had a gritty feel to them. The containers held rice, elbow macaroni, and spaghetti. 2. The door handles of each side of the oven and the door handle of the microwave continued to have a thick greasy substance and food particles. On 02/17/25 at 4:15 PM, the dinner meal was observed and CK2 confirmed the food was ready to be served to the residents. CK2 stated the dinner meal was pizza and Dijon chicken as the alternate with peas and carrots. The DM inserted the digital thermometer into a piece of Chicken, the temperature was 112 degrees Fahrenheit (F), while leaving the thermometer in the chicken, the temperature dropped to 110 degrees F then to 108 degrees F. The chicken was placed back into the oven. The chicken was removed at 4:21 PM and the temperature was 128 degrees F. The chicken was placed back into the oven until 4:45 PM when it was removed it was 203 degrees F. During this same time a thermometer was inserted into the mixed vegetables, the temperature was 124 degrees F. The mixed vegetables were placed in the oven and removed	F 812	achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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F 812	Continued From page 32 at 4:21 PM. The vegetables were 181 degrees F. The DM and CK2 agreed both the chicken and the vegetables were not at the correct temperature when they started the dinner service. On 02/19/25 at 9:45 AM, the Administrator said the temperature for the chicken should have been higher to be served. On 02/19/25 at 3:54 PM, the Registered Dietician (RD) stated she would do a monthly kitchen audit and would look at general labeling and dating. The RD stated she never really looked at the cleanliness of the kitchen. She stated the temperature for the chicken should be 165 degrees F on the steam table.	F 812		