STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175250	A. BUILDING _____ B. WING _____	08/21/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies represent the findings of a Health Resurvey. This 2567 was electronically sent to the facility on 08/27/24.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility reported a census of 43 residents with 14 sampled for review. Based on observation, interview, and record review, the facility failed to complete a "Significant Change Minimum Data Set" (MDS), within 14-days, as required, for two Residents (R)19 and R 44, regarding admission onto hospice care. Findings included: - Review of Resident (R)19 electronic medical record (EMR), revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).	F 637		

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

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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The "Significant Change Minimum Data Set" (MDS), dated 01/26/24, documented the resident's Brief Interview for Mental Status (BIMS) score to be four, indicating severe cognitive impairment. The resident did not have a condition or chronic disease which would result in a life expectancy of less than six months, and she did not receive hospice care during the assessment period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 01/26/24, documented the resident had a diagnosis of dementia.

The "Quarterly MDS," dated 08/06/24, documented the staff assessment for cognition revealed severe cognitive impairment. The resident had a condition or chronic disease that could result in a life expectancy of less than six months, and she received hospice care during the assessment period.

The care plan, revised 08/13/24, lacked staff instruction regarding hospice care.

Review of the resident's EMR revealed the following physician's order:

Admit to hospice care for the diagnosis of cerebrovascular disease (the death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), ordered 08/06/24.

On 08/20/24 at 01:51 PM, Administrative Nurse D stated the facility was not aware of the need to complete a significant change MDS when a

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resident admitted to hospice.

The facility utilized the "Resident Assessment Instrument" (RAI) in the completion of MDS's.

The facility failed to complete a significant change MDS, within the 14 -days, as required, for this resident who admitted to hospice care.

- Review of Resident (R)44's electronic medical record (EMR), revealed a diagnosis of cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The "Annual Minimum Data Set" (MDS), dated 06/13/24, documented the staff assessment for cognition revealed moderate impairment. The resident did not have a condition or chronic disease that could result in a life expectancy of less than six months. He did not receive hospice care during the assessment period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 06/24/24, documented the resident had impaired cognition related to a past CVA.

The "Quarterly MDS," dated 03/14/24, documented the staff assessment for cognition revealed moderate impairment. The resident did not have a condition or chronic disease which would result in a life expectancy of less than six months, and she did not receive hospice care during the assessment period.

The care plan, revised 07/25/24, instructed staff

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F 637	Continued From page 3 the resident received hospice care for end-of-life care and support. Review of the resident's EMR revealed the following physician's order: Admit to hospice care for the diagnosis of cerebrovascular accident (CVA-the death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), ordered 07/02/24. On 08/20/24 at 01:51 PM, Administrative Nurse D stated the facility was not aware of the need to complete a significant change MDS when a resident admitted to hospice. The facility utilized the "Resident Assessment Instrument" (RAI) in the completion of MDS's. The facility failed to complete a significant change MDS, as required, for this resident who admitted to hospice care.	F 637		
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: The facility reported a census of 43 residents with 14 sampled for review. Based on observation, interview, and record review, the facility failed to complete an accurate assessment/"Minimum Data Set" (MDS for four residents (R)23, R 37, R 2, and R 13 related to siderails used as restraints.	F 641		

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Findings included:

- Review of Resident (R)23's undated "Physician Orders" documented diagnoses which included hypertension (high blood pressure), chronic kidney disease, and heart failure.

The "Admission Minimum Data Set" (MDS) dated 10/05/23, documented the resident's "Brief Interview for Mental Status" (BIMS) score of 15, indicating cognitively intact. The MDS indicated bedrails not used as restraints (physical restraint are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body).

The "Quarterly MDS" dated 04/04/24, documented BIMS score of 15, indicating cognitively intact. The bedrails used as restraint daily.

The "Quarterly MDS" dated 08/04/24, documented a BIMS score of 15, indicating cognitively intact. The bedrails used as restraint daily.

Observation on 08/20/24 at 10:21 AM, revealed the resident as alert and oriented. She sat in her wheelchair and self-propelled her wheelchair about the room. There were bedrails at the head of the resident's bed.

On 08/19/24 at 12:10 PM, R 23 reported she requested the bedrails at the head of her bed. The bedrails did not restrict her movement in any way. She reported she used the bedrails to

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reposition herself in the bed and she would object to their removal.

On 08/20/24 at 01:53 PM, Certified Nurse Aide (CNA) N stated the facility did not have any residents that used bedrails as restraints. Residents used bedrails to increase their independence. R 23 preferred to lay in the bed with her legs positioned on a pillow. She used her bedrails to turn side to side.

On 08/21/24 at 10:29 AM, Licensed Nurse (LN) G confirmed the resident used the bedrails to position herself in the bed, turn from side to side, and enter and exit the bed. She had full access to her body. The bedrails did not restrict her movements but increased her independence. He stated the facility did not use restraints in the facility.

On 08/21/24 01:33 PM, Administrative Nurse D confirmed the above findings. She reported the facility did not use bedrails to restrain residents. She stated the MDS Coordinator had inaccurately coded bedrails used daily as a restraint.. She stated, upon review, inaccurate assessment affected 31 resident's assessments. Administrative Nurse D verified the bedrail use by the resident did not meet the definition of restraints as given in the "Resident Assessment Instrument Manual" (RAI), which the facility used for guidance to accurately compete the residents MDS.

The undated facility policy "Bedrails" documentation included each resident has the right to be free from any physical restraints. It is the policy of the facility to be restraint-free environment.

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The facility failed to complete an accurate assessment/"Minimum Data Set" (MDS for (R)23, related to bedrails used as restraint.

- Review of Resident (R)37's undated "Physician Orders" documented diagnoses which included pain, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) with current pathological fracture (broken bone caused by disease).

The "Admission Minimum Data Set" (MDS) dated 12/06/23, documented the resident's "Brief Interview for Mental Status" (BIMS) score of two, indicating severe cognitive impairment. The MDS indicated bedrails not used as restraints (physical restraint are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body).

The "Quarterly MDS" dated 03/07/24, documented BIMS score of one, indicating severe cognitive impairment. The bedrails used as restraint daily.

The "Quarterly MDS" dated 06/06/2424, documented BIMS score of one, indicating severe cognitive impairment. The bedrails used as restraint daily.

Observation on 08/19/24 at 12:36 PM, revealed the resident's bed with bedrails at the head of the

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bed.

On 08/19/24 at 12:10 PM, upon inquiry 37 reported she could move around without limitation. The bedrails helped her to move around.

On 08/20/24 at 01:53 PM, Certified Nurse Aide (CNA) N stated the facility did not have any residents that used bedrails as restraints. Residents used bedrails to increase their independence and self-position when in the bed. R 37 used her bedrails to enter and exit the bed independently. The resident is impulsive but the bedrails help her with her balance when she gets in and out of bed independently.

On 08/21/24 at 10:29 AM, Licensed Nurse (LN) G confirmed the resident used the bedrails to position herself in the bed, turn from side to side, and enter and exit the bed. She had full access to her body. The bedrails did not restrict her movements but increased her independence. He stated the facility did not use restraints in the facility. LN G reported the resident was impulsive and moved around the room getting in and out of bed independently.

On 08/21/24 01:33 PM, Administrative Nurse D confirmed the above findings. She reported the facility did not use bedrails to restrain residents. She stated the MDS Coordinator had inaccurately coded bedrails used daily as a restraint. She stated, upon review, inaccurate assessment affected 31 resident's assessments. Administrative Nurse D verified the bedrail use by the resident did not meet the definition of restraints as given in the "Resident Assessment Instrument Manual" (RAI), which the facility used

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for guidance to accurately compete the residents MDS.

The undated facility policy "Bedrails" documentation included each resident has the right to be free from any physical restraints. It is the policy of the facility to be restraint-free environment.

The facility failed to complete an accurate assessment/"Minimum Data Set" (MDS for (R)37 related to bedrails used as restraint.

- Review of Resident (R) 2's medical record revealed diagnoses that included femur (long bone in the thigh) fracture and chronic obstructive pulmonary disease (COPD progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Annual Minimum Data Set" (MDS), dated 04/08/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive status. The resident had no devices used as a restraint.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 04/08/24, assessed the resident with no weight bearing of the right extremity and on a turning and repositioning program with a pressure reducing mattress on her bed.

The "Quarterly MDS", dated 06/19/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13 which indicated normal

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cognitive status. The resident used a restraint of bed rails daily.

The "Care Plan" reviewed 08/01/24, instructed staff the resident use side rails for mobility and independence.

The "Siderail Use and Risk Assessment," dated 04/04/24, assessed the resident used two bed rails for the promotion of resident mobility, positioning, and independence. The device assisted to maintain proper body alignment.

Observation, on 08/19/24 at 1:11 PM, revealed the resident seated in her recliner in her room. The bed contained two quarter rails. Interview with the resident at that time revealed she had been bed bound for a while due to femur fracture, but now received therapy. The resident stated she used the rails to help turn and reposition when in bed, but now slept in her recliner.

Interview, on 08/19/24 at 1:30 PM, with Administrative Nurse D and Administrative Staff A, revealed the facility was restraint free, and confirmed the MDS inaccurately coded the bed rail as a restraint.

The facility policy "Bed Rails" undated, instructed staff the facility was to provide a restraint free environment. If a bed rail is used the facility will ensure individual bed rail assessments and evaluations are performed on a regular basis.

The facility follows the RAI (Resident Assessment Instrument) Manual for the completion of the MDS.

The facility inaccurately assessed this resident's

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use of side rails as a restraint on the MDS dated 06/19/24.

- Review of Resident (R) 13's medical record, revealed diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain).

The "Annual Minimum Data Set" (MDS), dated 01/11/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderately impaired cognitive status. The resident utilized two bed rails as a physical restraint daily.

The "Cognitive Loss Care Area Assessment" (CAA) dated 01/11/24, assessed the resident utilized bed rails for positioning assistance.

The "Quarterly MDS" dated 04/11/24,assessed the resident daily use of bed rail as a restraint.

The "Quarterly MDS" dated 07/11/24, assessed the resident daily use of bed rail as a restraint.

The "Care Plan" reviewed 06/25/24, instructed staff the resident used side rails for independence and mobility.

The "Siderail Use and Risk Assessment," dated 04/06/24 and 07/09/24, assessed the resident utilized bed rails to maintain proper body alignment.

Observation, on 08/20/24 at 09:13 AM, revealed the resident positioned in bed with two quarter

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F 641	Continued From page 11 bed rails in the down position. Certified Nurse Aide (CNA) O and P used a draw sheet to turn and reposition the resident to prepare for transfer with a mechanical lift. CNA P stated the resident did not usually assist staff to turn with the use of side rails. Interview, on 08/21/24 at 01:00 PM, with Administrative Nurse D, confirmed the MDS coding of the bed rail as a restraint was inaccurate. Administrative Nurse D stated the facility was restraint free. The facility policy "Bed Rails" undated, instructed staff the facility was to provide a restraint free environment. If a bed rail is used, the facility will ensure individual bed rail assessments and evaluations are performed on a regular basis. The facility follows the RAI (Resident Assessment Instrument) Manual for the completion of the MDS. The facility inaccurately assessed this resident's use of side rails as a restraint on the MDS, dated 01/11/24, 04/11/24 and 07/11/24.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		

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assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 43 residents with 14 sampled for review. Based on

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observation, interview, and record review, the facility failed to complete a comprehensive care plan for one Resident (R)19, regarding admission onto hospice care.

Findings included:

- Review of Resident (R)19 electronic medical record (EMR), revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The "Significant Change Minimum Data Set" (MDS), dated 01/26/24, documented the resident's Brief Interview for Mental Status (BIMS) score to be four, indicating severe cognitive impairment. The resident did not have a condition or chronic disease which would result in a life expectancy of less than six months, and she did not receive hospice care during the assessment period.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 01/26/24, documented the resident had a diagnosis of dementia.

The "Quarterly MDS," dated 08/06/24, documented the staff assessment for cognition revealed severe cognitive impairment. The resident had a condition or chronic disease that could result in a life expectancy of less than six months, and she received hospice care during the assessment period.

The care plan, revised 08/13/24, lacked staff instruction regarding hospice care.

Review of the resident's EMR revealed the

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	175250	A. BUILDING _____ B. WING _____	08/21/2024

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WELLSVILLE MANOR	304 W 7TH ST WELLSVILLE, KS 66092

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F 656	Continued From page 14 following physician's order: Admit to hospice care for the diagnosis of cerebrovascular disease (the death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), ordered 08/06/24. On 08/20/24 at 01:51 PM, Administrative Nurse D stated a resident's care plan should include hospice care instructions for the staff. The facility policy for "Care Plan Revisions", undated, included: When changes in a resident's condition occurs, the plan of care will be updated timely. The care plan will be revised when a resident or their family makes the decision to accept hospice services. The care plan shall include detailed and comprehensive instructions to staff on which staff from which specific organization provides services and equipment for the care of the resident and support to the family. The facility failed to complete a comprehensive care plan for this resident who admitted to hospice care.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		

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F 695	Continued From page 15	F 695		

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 43 resident with 14 residents selected for review, which included two residents reviewed for respiratory needs. Based on observation, interview, and record review, the facility failed to provide appropriate nebulizer equipment for one of the two Residents (R)2.

Findings included:

- Review of Resident (R) 2's medical record revealed diagnoses that included femur (long bone in the thigh) fracture and chronic obstructive pulmonary disease (COPD progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Annual Minimum Data Set" (MDS), dated 04/08/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 13, which indicated normal cognitive status.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 04/08/24, assessed the resident with COPD and slept with the head of the bed elevated due to shortness of breath when lying flat.

The "Care Plan" reviewed 08/01/24, instructed staff the resident received oxygen therapy and to observe for signs and symptoms of oxygen deprivation and assess lung sounds as needed. The resident may receive inhalers and breathing treatments in dining area/public areas if she chose.

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F 695	Continued From page 16	F 695		

A "Physician Order" dated 08/18/24, instructed staff to administer ipratropium-albuterol (medications used to dilate airways) breathing solution for nebulization (a technique that require a machine and mask or handheld mouthpiece that turns liquid medication into a mist to inhale into the lungs), 0.5 milligrams (mg)-3 mg (2.5 mg base)/3 ml, every six hours, through 08/20/24.

Review of the "Medication/Treatment Administration Record" dated August 2024, revealed the resident received administration of the ipratropium-albuterol medication on 08/18/24 at 12:00 PM and 06:00 PM, and on 08/19/24 at 06:00 AM (12:00 PM not administered due to wrong size mask) and 09:26 PM (15 and a half hours later).

A "Nurse Note" dated 08/19/24 at 02:31 PM, notified the physician of a delay in providing the breathing treatment due to unavailable supplies.

A "Physician Order" dated 08/20/24, instructed staff to administer the above order through 08/23/24.

Observation, on 08/19/24 at 12:47 AM, revealed Certified Medication Aide (CMA) M, prepared to administer the ipratropium-albuterol medication for nebulization. CMA M noted the mask used to place over the resident's nose and mouth was a pediatric (child) size and did not fit the resident appropriately to ensure R2 received the full benefit of the medication. CMA M searched the facility for an appropriately sized mask or handheld inhalation device and was unable to locate one.

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F 695	Continued From page 17 Interview, on 08/19/24 at 02:18 PM with Licensed Nurse G, confirmed the facility received pediatric masks instead of the ordered adult masks. Interview, on 08/19/24 at 04:30 PM, with Administrative Nurse D, revealed staff obtained the appropriate nebulizer supplies through a local retailer. The facility policy "Nebulizer Treatment" undated, instructed staff to provide safe and effective delivery of medication to the trachea (windpipe the connection from the voice box (larynx) to the lungs, bronchi (two tubes that connect the lungs to the trachea) and or lungs using proper technique and universal precautions. The facility failed to provide proper nebulizer equipment for R2 to ensure optimal effectiveness of ipratropium-albuterol.	F 695		
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.	F 812		

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F 812	Continued From page 18	F 812		

§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:
The facility reported a census of 43 residents. Based on observation, record review and interview, the facility failed to prepare and serve food under sanitary conditions, to the residents of the facility appropriately to prevent the potential for food borne bacteria.

Findings included:

- During an initial tour of the kitchen on 08/20/24 at 07:41 AM, the following areas of concern were noted:

1. The trash can in the dish washing area contained dried-on food and liquid substances on all sides and the lid.

2. The trash can by the hand washing sink contained dried-on food and liquid substances on all sides and the lid.

3. The shelf underneath a preparation table which held plastic pitchers, cutting boards and clean eating utensils, contained food debris.

4. The inside of the microwave contained dried-on food on all sides and the top.

5. Four colored cutting boards contained deep grooves and were discolored.

6. An oscillating fan had a build-up of dust in the slats of the fan.

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7. One side of the stove had dried-on food substances.

8. One of two reach-in freezers had a build-up of food substances on the bottom.

9. One of two reach-in freezers had a build-up of food substances on the bottom and a build-up of a black substance in the rubber door seals.

10. Three plastic tubs, beneath a prep table, which held clean cooking utensils, contained a sticky substance on the bottom of the tubs.

11. Five plastic containers on a wire rack which contained clean kitchen utensils, had a heavy build-up of food debris and a sticky substance on the container latches.

12. The table holding the large stand mixer, had a build-up of food substance on the bottom shelf, holding the two large mixing bowls.

On 08/21/24 at 10:50 AM, Dietary staff BB confirmed the areas of concern and stated the areas would need to be included on a cleaning schedule.

The facility lacked a policy for kitchen cleanliness.

The facility failed to prepare and serve food under sanitary conditions for the residents of the facility appropriately to prevent the potential for food borne bacterial.