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	255163	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL WOODLAND VILLAGE NURSING CENTER	5427 GEX ROAD DIAMONDHEAD, MS 39525

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with six (6) Complaint Investigations (CI MS #23240, CI MS #23523, CI MS #24140, CI MS #24207, CI MS #24236, and CI MS #24278), at the facility from 02/26/24 through 02/29/24. The SA investigated CI MS #23240 for residents not allowed snacks, no refrigerators in their rooms, and food choices and taste and cited F809. The SA investigated CI MS #23523 for a facility reported incident related to pest control and cited F925. The SA investigated CI MS #24207 for a facility reported incident related to misappropriation of funds and cited F602. The SA investigated CI MS #24278 for resident neglect related to not properly groomed, resident with body odor and pressure wounds and not assisting resident with feeding and cited F677. The SA investigated CI MS #24140 related to falls and CI MS #24236 for facility staffing, not answering call lights in a timely manner, and quality of care, and there were no citations related to those complaints. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F656, F690, and F812. The facility had a census of 115 and was licensed for 132.	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,	F 565		4/10/24

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

Electronically Signed | 03/21/2024

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F 565	Continued From page 1 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 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 interviews, record review, and review of resident council monthly meeting minutes, the facility failed to resolve grievances regarding food complaints for five (5) of eight (8) months reviewed. Findings include:	F 565	F565- Resident/Family Group Response An in-service was started by the Dietary Manager (DM) on 2/28/24 for dietary staff on following the recipe, food presentation, portion sizes and calibration of thermometers.	

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F 565	Continued From page 2 Review of the Resident Council minutes revealed the residents complained about the food during their meetings in October 2023, November 2023, December 2023, January 2024, and February 2024. A record review of a written letter, dated 2/5/24, from the Resident Council President revealed the resident council had concerns regarding the food. During an interview on 02/26/24 at 10:32 AM, with the Ombudsmen stated the residents invited him to their last resident council meeting. The Ombudsmen stated "the residents complained about the food being cold and not tasting good." The Dietary Manager (DM) attended that meeting. During an interview on 2/29/24 at 1:00 PM, with the Activities Director (AD), she confirmed that she recorded the minutes at the Resident Council meetings and the residents complained every month for the last five (5) months about the food. The AD explained the residents complained about the taste and the temperature of the food and she had reported their complaints to the DM and the Administrator. During an interview on 2/29/24 at 1:30 PM, with the DM she confirmed the residents have been complaining about the food being cold and not palatable for several months. She explained the previous Administrator was going to buy new food warmers to help with the temperature of the food and she would discuss this issue with the current Administrator. During an interview on 2/29/24 at 02:00 PM, with the Administrator, she confirmed the residents	F 565	All residents have the potential to be affected by this practice. In-service started and ongoing on 2/28/24 for dietary staff on following the recipe, food presentation, portion sizes and calibration of thermometers. All Dietary staff will be required to complete mandatory in-service prior to working after 4/8/24.Systems Manager held a Focus Group with 5 residents on 3/13/24 to discuss concerns. A follow up meeting is scheduled on 4/5/2024. Maintenance was called to inspect equipment for proper function on 3/4/24. It was determined the plate warmer and heating sham were not working properly. Parts were ordered on 3/14/24 to improve the function of the plate warmer and heating sham. All Dietary staff will be required to complete mandatory in-service prior to working after 4/1/24. Daily rounds were started on 3/4/24 by Dietary Manager using MyRounding tool to document daily rounds with 10-15 residents times 4 weeks then once a week times 4 months. Systems Director or Dietician follows up on any negative input. Weekly audits of temperatures and taste will be audited twice weekly starting 3/4/24 times 4 weeks then weekly times 4 months. Finding were brought by DM to initial Quality Assurance Performance Improvement Committee (QAPI) meeting on 3/12/24. DM will bring findings to next QAPI meeting on 4/9/24 for review and follow up for any recommendations for additional education monthly times 4	

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F 565	Continued From page 3 had complained about the food being cold and not tasting good. She stated she would be talking with the resident to get these issues corrected.	F 565	months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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	F 656		4/10/24

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F 656	Continued From page 4 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to implement care plan approaches related to an indwelling catheter care for one (1) of 23 sampled residents. Resident #70 Findings include: A record review of the facility's policy "Care Plans, Comprehensive Person-Centered", revised December 2022 revealed " ... A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The Interdisciplinary Team ...implement a comprehensive, person-centered care plan for each resident ... 7. The comprehensive, person-centered care plan will: ... b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..."	F 656	F 656 Develop/Implement Comprehensive Care Plan The Minimum Data Set (MDS) Nurse implemented the Comprehensive Care Plan for Catheter care for resident #70 on 9/15/23 including wipe front to back when providing catheter care and to secure the catheter tubing using a leg strap. CNA #3 and #4 failed to utilize a leg strap during catheter care and wiped back to front. An in-service was conducted immediately on 2/27/24 on Catheter Care for CNA #3 and #4 by Staff Development nurse. Resident #70 catheter was cleaned properly immediately. All residents with indwelling catheters have the potential to be affected by this deficient practice. An in-service was conducted immediately on 2/27/24 and ongoing by Staff Development Nurse for all CNA's on Catheter Care for residents with indwelling	

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F 656	Continued From page 5 Record review of the Care Plan with a problem onset date of 9/15/2025 revealed "Problem/Need ...high risk for UTI (Urinary Tract Infection) r/t (related to) presence of indwelling foley (type of indwelling catheter) ...Approaches ...Wipe front to back when providing pericare ...Secure catheter tubing using leg strap ..." During an observation and interview on 2/27/24 at 11:00 AM, Certified Nurse Aide (CNA) #3 and CNA #4 provided catheter care for Resident #70. There was no leg strap securing the catheter tubing to reduce the risk of tension or pulling on the catheter to prevent trauma. Both CNAs reported the resident does not wear a leg strap because the resident would pull it off. CNA #3 used a disposable wipe and wiped the perineal area from the from the back to the front. CNA #4 reminded CNA #3 that she should wipe from the front to the back. After discarding the wipe and repositioning the resident, CNA #3 used a disposable wipe to clean the catheter by wiping the tubing several times, using the same wipe, and not changing the position of the wipe. After completing the care, CNA #3 reported she was unsure how many times she wiped the catheter with the disposable wipe, but thought it was at least five (5) to six (6) times and explained she was nervous. During an interview with the Director of Nursing (DON) on 02/27/24 at 12:00 PM, she explained all residents with a catheter should have a leg strap to secure the catheter. She stated that CNAs should inform the nurse if a resident does not have a leg strap. She said she expected all CNAs to perform catheter care properly. The DON also stated that she expected the staff to follow the resident's care plan.	F 656	catheters. CNA's will not be permitted to work until in-serviced on Catheter Care after 4/1/24. Staff Development Nurse began observation of Foley catheter care on 3/4/24 x 4 weeks on 3 residents with indwelling catheters then monthly x 4 months. Finding were brought by Staff Development Nurse to initial Quality Assurance Performance Improvement Committee (QAPI) meeting on 3/12/24 for review and follow up for any recommendations for additional education. SD will bring finding to next QAPI meeting on 4/9/24 then monthly times 3 months.	

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F 656	Continued From page 6 On 02/29/24 at 4:40 PM, during an interview with Licensed Practical Nurse (LPN)#3/Care Plan Nurse she explained she expected the staff to review and follow resident's care plans because they are individualized and inform the staff how to care for the resident. Record review of the "Face Sheet" revealed the facility admitted Resident #70 on 7/27/23 with current diagnoses including Neuromuscular Dysfunction of Bladder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/12/24 revealed Resident #70 required a Staff Assessment for Mental Status which indicated her cognition was severely impaired.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review the facility failed to provide showers for residents who require assistance for three (3) of (23) sampled residents. (Residents #74, #78 and #97) Findings Include: Review of the facility's policy, "Activities of Daily Living" (ADL's)", revised 11/28/2023, revealed ...The facility will, based on the residence	F 677	F677 ADL Director of Nursing (DON), Assistant Director of Nursing (ADON) and Resident Care Manager's (RCM) immediately audited bath schedules and shower sheets on 2/28/24. Resident #97 was no longer a resident at the facility, Resident #78 had received a bath that day, 2/28/24, and Resident #74 was offered a bath but chose to wait the following day, 2/29/24,	4/10/24

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F 677	Continued From page 7 comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate ...Care and services will be provided for the following activities of daily living ...1. Bathing, dressing, grooming ..." Review of the facility policy, "Resident Showers", revised 11/29/23, revealed, " ...It is the practice of this facility to assist residents with bathing to maintain proper hygiene ...Policy Explanation and Compliance Guidelines ...1. Residents will be provided showers are per request or as per facility schedule protocols ..." Resident #74 On 2/28/29 at 04:50 PM, in an interview with Resident #74, she stated that she does not receive a shower consistently. The resident explained that she received a shower on Tuesday, Thursday, and Saturday and she did not receive a shower the previous day, which was a Tuesday. The resident said that she hoped she would get a shower tomorrow because the staff give showers whenever they want to and not when it is scheduled. A record review of the facility's, "Activities of Daily Living (ADL) Assistance and Support" documentation revealed Resident #74 received four (4) showers for the month of February. A record review of the "Face Sheet" revealed the facility admitted Resident #74 on 2/22/20 and she had current diagnoses Muscle Weakness. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date	F 677	for her scheduled bath day. All residents have the potential to be affected by this practice. An in-service was conducted on 2/29/24 and ongoing by Staff Development Nurse for all Certified Nursing Assistant's (CNA) on following bath schedules, any missed or refused showers will be reported to DON. ADON or RCM for follow up. CNA's will not be permitted to work until in-serviced after 4/1/24. DON, ADON and/or RCM started monitoring the shower schedule on 2/29/24 daily x 4 weeks then monthly for 4 months and interviewing 3 Residents weekly to confirm shower was performed weekly times 4 weeks then monthly times 4 months. Starting on 2/29/24 floor nurse and CNA will sign off on shower schedule to confirm shower was performed. Finding were brought by DON to initial Quality Assurance Performance Improvement Committee (QAPI) meeting on 3/12/24 for review and follow up for any recommendations for additional education. DON will bring finding to next QAPI meeting on 4/9/24 then monthly times 3 months.	

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F 677	Continued From page 8	F 677		

(ARD) of 12/26/23 revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated her cognition was moderately impaired.

Resident #78

During an interview on 02/28/24 at 4:46 PM, with a Resident #78's family member, she explained that every time she visited her mother, she was dirty, and her hair was greasy. She stated that her family member was not getting bathed, and she had previously met with the Director of Nursing (DON) and other staff regarding this matter.

During an interview on 02/28/24 at 04:50 PM, with Resident #78, she explained that she was incontinent and needed to have showers, but she had to have help.

During an interview on 02/28/24 at 05:00 PM, with Licensed Practical Nurse (LPN) #2, she explained she was the cart nurse for the hall. She stated that she has not been told by a nurse aide that the resident refused her shower.

During an interview on 2/28/24 at 05:10 PM, with Certified Nurse Aide (CNA) #5, she stated that Resident #78 often refused to take a shower. She acknowledged that the resident's family visited and wanted to know why the resident was dirty and she explained that the resident refused to take showers. CNA #5 confirmed Resident #5 had not received a shower at 4:30 PM because the resident had refused, but she did not notify the nurse or the DON that the resident had refused.

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A record review of the "ADL Assistance and Support" documentation for February 2024 revealed Resident #78 was dependent upon staff for bathing and received five (5) baths for the month of February.

A record review of the "Face Sheet" revealed the facility admitted Resident # 78 on 7/31/23 and she had current diagnoses including Hypertension.

A record review of the MDS with an ARD of 12/26/23 revealed Resident #78 had a BIMS score of 11, which indicated her cognition was moderately impaired.

Resident #97

In a phone interview on 2/26/24 at 2:00 PM, with the social worker at the local hospital, she stated she received report from the emergency room medical doctor and nurses that Resident #97 was dirty, unkempt, and had an odor when he arrived from the facility. She confirmed the resident was currently admitted to the hospital.

During an interview on 2/26/24 at 5:00 PM, with Resident #97's family member, she confirmed Resident #97 was sent to the hospital dirty and unkempt. The wife said she told the hospital staff that he was always dirty and had odors.

A record review of the "ADL Assistance and Support" document for February 2024 revealed Resident #97 was dependent upon staff for bathing and received one (1) bath on 2/14/24 for the month of February.

A record review of the "Face Sheet" revealed the

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F 677	Continued From page 10	F 677		

facility admitted Resident #97 on 8/16/22 and he had current diagnoses including Alzheimer's Disease.

A record review of the MDS with an ARD of 12/19/23 revealed Resident #97 had a BIMS score of 8, which indicated his cognition was severely impaired.

During an interview 02/29/24 at 09:31 AM with the DON, she confirmed there was no documentation on the shower sheets to show Resident #78 had received showers three (3) times per week and confirmed she had recently met with the resident's family. The DON said she believed the CNAs were giving showers but were not documenting it on the computer. The DON explained that if a resident refused a shower, the CNAs are trained to document the refusal and notify the nurse, and the cart nurse should notify the charge nurse so the charge nurse can further encourage the resident. If a resident continues to refuse a bath, then the Assistant Director of Nurses (ADON) and DON should be notified. The DON explained the shower schedule is set up for residents who are on the "A" bed received showers on Monday, Wednesday, and Friday and the residents on the "B" bed received showers on Tuesday, Thursday, and Saturday. The DON said the charge nurse was responsible for monitoring the CNAs to ensure the showers and baths were given. The DON also said she was not aware that Resident #74 was not getting a shower.

During an interview on 02/29/24 at 10:00 AM, with the Administrator, she revealed she was not aware residents were not getting their baths or showers. The Administrator said she was going to make changes to ensure the resident's needs

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F 677	Continued From page 11 and preferences were being met.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		4/10/24

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	255163	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 690	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent complications for one (1) of one of seven (7) residents with urinary catheters. Resident #70 Findings include: A record review of the facility's policy "Catheter Care", dated 10/2022 revealed, " ... It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ... Policy Explanation: ... Female ...10. Wipe from front to back with a clean cloth ... 11. Use a new part of the cloth or different cloth for each side. 12. With a new moistened cloth ...wipe the catheter ..." At 11:00 AM on 02/27/24, during an observation and interview, Certified Nurse Aide (CNA) #3 and CNA #4 provided catheter care for Resident #70. There was not a leg strap securing the catheter tubing to reduce the risk of tension or pulling on the catheter to prevent trauma. Both CNAs reported the resident does not wear a leg strap because the resident would pull it off. CNA #3 used a disposable wipe and wiped the perineal area from the from the back to the front. CNA #4 reminded CNA #3 that she should wipe from the front to the back. After discarding the wipe and repositioning the resident, CNA #3 used a disposable wipe to clean the catheter by wiping the tubing several times, using the same wipe, and not changing the position of the wipe. After completing the care, CNA #3 reported she was unsure how many times she wiped the catheter	F 690	F 690- Bowel/Bladder Incontinence, Catheter, UTI Certified Nursing Assistant (CNA) #3 and #4 failed to utilize a leg strap during catheter care and wiped back to front for Resident #70. An in-service was conducted immediately on Catheter Care for CNA #3 and #4 by Staff Development nurse on proper procedures to prevent possible complications. Resident #70 was given proper catheter care immediately. All residents with indwelling catheters have the potential to be affected by this deficient practice. An in-service was conducted on 2/27/24 and ongoing by Staff Development (SD) Nurse for all CNA's on providing catheter care on residents with indwelling catheters. CNA's will not be permitted to work until in-serviced on Catheter Care after 4/1/24. Staff Development Nurse began observation of Foley catheter care on 3/4/24 x 4 weeks on 3 residents with indwelling catheters then monthly x 4 months. Finding were brought by Staff Development Nurse to initial Quality Assurance Performance Improvement Committee (QAPI) meeting on 3/12/24 for review and follow up for any recommendations for additional education. SD will bring finding to next	

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F 690	Continued From page 13 with the disposable wipe, but thought it was at least five (5) to six (6) times and explained she was nervous. On 02/27/24 at 12:00 PM, during an interview with the Director of Nursing (DON), she explained all residents with a catheter should have a leg strap to secure the catheter. She stated that CNAs should inform the nurse if a resident does not have a leg strap. She said she expected all CNAs to perform catheter care properly and explained the facility completed competency check offs for CNAs yearly. Record review of the "Face Sheet" revealed the facility admitted Resident #70 on 7/27/23 with current diagnoses including Neuromuscular Dysfunction of Bladder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/12/24 revealed Resident #70 required a Staff Assessment for Mental Status which indicated her cognition was severely impaired. Section H revealed Resident #70 had an indwelling catheter.	F 690	QAPI meeting on 4/9/24 then monthly times 3 months.	
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and	F 809		4/10/24

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F 809	Continued From page 14 breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and the facility policy review the facility failed to offer residents in the facility a bedtime snack for (3) of 23 sampled residents. (Resident #94, Resident #95, and Resident #107). Findings Include: A review of the facility's policy, "Offering/Serving Bedtime Snacks", revised 4/20/23, revealed, "...It is the practice of this facility to offer and serve residents with a nourishing snack in accordance with their needs, preferences and requests at bedtime on a daily basis ...Policy Explanation and Compliance Guidelines ...1. The nursing staff offers bedtime snacks to all residents ..." Resident #94 On 02/27/24 at 01:30 PM, in an interview with Resident #94, she explained she has not noticed the staff offering snacks to residents in the facility, or taking bedtime snacks to residents who are unable to leave their room. She said that if she asked for a snack, the staff would provide it.	F 809	F809: Frequency of Meals/Snacks at Bedtime On 2/29/24 and ongoing an in-service was conducted with all Certified Nursing Assistant's (CNA) and Nurses on offering bedtime snacks to all residents. Resident #94, Resident #95 and Resident #107 were shown snack choices and informed they would be offered a snack every evening on 2/29/24 by Director of Nursing (DON). All residents with have the potential to be affected by this practice. CNA's and Nurses were in-serviced on offering bedtime snacks to all residents. Residents were informed snacks are available at night; signs with visuals of possible snacks were posted in all resident's rooms. Electronic Health Record (EHR) documentation was added for nurses to offer snacks and chart on 3/12/24.	

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F 809	Continued From page 15 A record review of the "Face Sheet" revealed the facility admitted Resident #94 on 12/21/22 and she had current diagnoses including Type 2 Diabetes Mellitus. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/01/24 revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Resident #95 On 02/27/24 at 01:30 PM, an interview with Resident #95, he stated that he had never been offered a snack after dinner and did not know that bedtime snacks were available. A record review of the "Face Sheet" revealed the facility admitted Resident #95 on 11/10/22 and he had current diagnoses including Hypertension. A record review of the Quarterly MDS with an ARD of 12/27/23 revealed Resident #95 had a BIMS score of 14, which indicated he was cognitively intact. Resident #107 On 02/26/24 at 11:39 AM, an interview with Resident #107 revealed the activities staff offered snacks to the residents after breakfast and lunch, but there was no snack offered at bedtime. The resident reported mainly staying in her room and seldom ventures down the hall. The resident stated she has not been offered an after-dinner snack in the time she has been at the facility. A record review of the "Face Sheet" revealed the	F 809	Director of Nursing (DON) or Assistant Director of Nursing (ADON) began auditing charting on nighttime snacks on 3/12/24 weekly times 4 weeks and monthly times 4 months. Social Services began interviewing ten (10) residents weekly to ask if nighttime snacks were offered on 3/4/24 times for four (4) weeks then monthly times 4 months. Finding were be brought to initial Quality Assurance Performance Improvement Committee (QAPI) meeting by DON for review and follow up for any recommendations for additional education on 3/12/24.DON will bring findings to next QAPI meeting on 4/9/24 then monthly times 3 months.	

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F 809	Continued From page 16 facility admitted Resident #107 on 01/31/24 with current diagnoses including Osteoarthritis. A record review of the Admission MDS with an ARD of 2/07/24 revealed Resident #107 had a BIMS score of 14, which indicated he was cognitively intact. On 02/27/24 at 03:13 PM, an interview with the Assistant Director of Nursing (ADON) revealed snacks are brought from the kitchen at 10 AM and 2 PM and the Activities staff offered them to the residents. The ADON confirmed there was no bedtime snacks offered, but if a resident wanted a snack, they could ask a nurse. On 02/29/24 at 12:07 PM, in an interview with the Administrator, she confirmed that although snacks were available upon request, all residents were not offered a bedtime snack. She stated that going forward, the nursing staff would offer all residents a bedtime snack.	F 809		
F 812 SS=D	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.	F 812		4/10/24

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F 812	Continued From page 17 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to store food and engage in sanitary practice in accordance with professional standards for food service safety related to food items not dated with a use-by-date, no identifying label, expired foods, improperly stored and exposed food for one (1) of three (3) kitchen observations. Findings include: A review of the facility's policy, "Food Safety Requirements", revised 9/20/22, revealed, " ...Foods will also be stored, prepared, distributed and served in accordance with professional standards for service safety...Policy Explanation and Compliance Guidelines "Policy...1. Food safety practices shall be followed ...b. Storage of food in a manner that helps prevent ...contamination of food ...3. Facility shall inspect all food ...C. Refrigerated storage ...iv. Labeling, dating and monitoring refrigerated food ...so it is used by its use-by date ..." On 02/26/24 at 10:10 AM, an observation with the Dietary Manager (DM) revealed the following: 1. Refrigerator #1 contained 24 (4)-ounce (oz) containers of apple juice with no use by date, one (1) 4 oz container of cranberry flavored juice cocktail with no use by date, one (1) opened 46	F 812	F812- Food Procurement, Store/Prepare/Serve-Sanitary All expired and non-labeled food was disposed. An in-service was started by Dietary Manager (DM) with dietary staff on 2/28/2024 on proper labeling, storage and inspection of dates to ensure they are not expired. All residents have the potential to be affected by this practice. A daily checklist will be performed starting 3/4/24 by Dietary Manager (DM) to check for proper labeling, storage and expirations dates. All Dietary staff will be required to complete mandatory in-service prior to working after 4/8/24. The Dietician and/or Systems Manager will audit the checklist weekly times 4 weeks then once a month times 4 months starting 3/4/24. Finding were brought to initial Quality Assurance Performance Improvement Committee (QAPI) meeting on 3/12/24 by DM for review and follow up for any recommendations for additional education. DM will bring audit to next QAPI meeting on 4/9/24 then monthly times 3 months.	

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F 812	Continued From page 18	F 812		

oz jar of apple sauce opened on 2/22/24 and was good though 2/25/25, one (1) opened 46 oz jar of apple sauce with no use by date, one (1) tray containing six (6) 4 oz containers of orange juice with no use by date, and eight (8) - 4 oz containers of apple juice with no use by date.

2. Refrigerator #2 contained two (2) unopened bags of coleslaw with a use by date of 2/23/24. One (1) unopened gallon of milk with the "best by" date of 02/16/24. One (1) opened gallon of milk with the "best by" date of 02/16/24, one (1) opened quart carton of heavy cream with no use by date, one (1) opened five (5) pound block of processed cheese with no use by date.

3. Freezer #2 contained one (1) opened and exposed plastic bag of hash browns with no identifying label or manufacturer date and 1 (one) opened bag of diced chicken with no identifying label and no manufacturers date.

4. An observation of the pantry revealed the sugar bin lid was not secured and left a large gap, leaving the sugar exposed.

On 02/28/24 at 8:09 AM, in an interview with the DM, she acknowledged the outdated, improperly stored, and exposed foods. The DM reported it is her responsibility to label and check expiration dates for food items. She explained the kitchen staff receive monthly in-service training on food safety.

On 02/29/24 at 12:07 PM, in an interview with the Administrator, she confirmed she had been made aware of the issues in the dietary department related to outdated, improperly stored, and exposed foods in the kitchen.

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