| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 015458 | A. BUILDING ______ B. WING ______ | 04/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AHC MILLENIUM** | **5275 MILLENNIUM DRIVE HUNTSVILLE, AL 35806** |

| (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 |
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| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, review of Resident Identifier (RI) #58's medical record and the facility's policy titled "Restraint Policy" the facility failed to provide medical justification of a physical restraint for RI #58, one of one sampled | F 604 | THIS PLAN OF CORRECTION CONSTITUTES A WRITTEN ALLEGATION OF SUBSTANTIAL COMPLIANCE WITH FEDERAL MEDICARE AND MEDICAID | 5/27/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/17/2021

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 604 | Continued From page 1<br>residents reviewed for physical restraints. RI #58, who is assessed as requiring limited assistance with transfers and mobility was observed in a locked, reclined Geri-chair that prevented the resident from getting up and walking.<br><br>Findings include:<br><br>The facility's policy titled, "Restraint Policy" last reviewed May 2020, documented "Definitions: Physical Restraints refers to 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 ... Policy: Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints ... Physical restraints may include, but are not limited to: ... d. Using devices in conjunction with a chair or merry walker, such as trays, bars or belts, that the resident cannot remove easily, that prevent the resident from rising or leaving the chair/walker. d. Placing a resident in a chair that prevents a resident from rising ... ."<br><br>RI #58 was admitted to the facility on 3/16/2021 with diagnoses that included Difficulty Walking, Depressive Disorder, and Dementia.<br><br>RI #58's Admission Minimum Data Set (MDS) with an assessment reference date of 3/19/2021 indicated the resident was severely impaired in cognitive skills with a Brief Interview for Mental | F 604 | REQUIREMENTS.<br><br>1.On 4/21/21 DON placed the back of the geri-chair in upright position and unlocked the geri-chair. The DON informally in-serviced staff working on 4/21/21 not to recline or lock the geri-chair. DON made rounds to make sure the chair was not reclined or locked throughout the day.<br>2.All residents have the potential to be affected by this deficient practice. Other residents in geri chairs will be assessed by 05/21/2021 by therapy for proper chair positioning.<br>3.Therapy assessed RI#58 on 4/23/21 for use of the geri- chair. RI#58 was switched to a wheelchair and the geri-chair was removed from her room.<br>All nursing staff were in-serviced on 4/30/21 on not placing a resident in a geri-chair unless assessed and recommended for a geri-chair by therapy and a restraint assessment completed by nursing staff.<br>All nursing staff will be in-serviced on our restraint policy on 5/21/21.<br>4.An audit tool was created by the DON on 04/26/2021 to check for any issues with residents that are in geri chairs. The audit tool will track residents in geri-chairs to monitor if they have all been assessed by therapy and found appropriate and have a restraint assessment completed. The DON or designee will audit x 5 a week for the first month, then x 3 a week for the second month, then x 2 a week for the third month to ensure continued compliance. The DON began monitoring | |

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| F 604 | Continued From page 2 | F 604 | | |

Status (BIMS) score of seven. RI #58 was assessed as required limited assistance with transfers and mobility.

A review of RI #58's care plan did not indicate the use of reclined Geri-chair.

Further review of Resident #58's clinical record revealed there was no documented evidence the resident was assessed for the use of the Geri-chair.

On 4/20/2021 at 10:44 AM, RI #58 was observed sitting in front of the nurse's station in a reclined Geri-chair.

On 4/21/2021 at 12:18 PM, RI #58 was observed sitting in front of the nurse's station in a reclined Geri-chair.

On 4/21/2021 at 1:44 PM, RI #58 was observed sitting in front of the nurse's station in a reclined Geri-chair.

On 4/21/2021 at 2:03 PM, Employee Identifier (EI) #1, a Registered Nurse (RN) was asked to observe RI #58 seated in a reclined Geri-chair. EI #1 verified that RI #58 was seated in the Geri-chair in front of the nurse's station in the reclined position. EI #1 stated RI #58 was placed there in the reclined Geri-chair because the resident kept getting out of the chair and walking around the facility. EI #1 stated RI #58 was a fall risk and not stable when walking. When asked if the reclined Geri-chair was a restraint, EI #1 stated in a way the Geri-chair is a restraint.

On 4/21/2021 at 2:13 PM, EI #2, the Director of Nursing (DON) was asked to observe RI #58 in

**Provider's Plan of Correction (F 604):**

with the audit tool on 4/26/21. Any issues of non-compliance will be addressed immediately. Results from audits will be included in our QAPI process and brought to our monthly QAPI meeting for three months and longer if any issues exist. The QAPI meeting this month will be held on Thursday May 27,2021.

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| F 604 | Continued From page 3<br>the reclined Geri-chair. EI #2 acknowledged the resident was seated in a reclined Geri-chair. Upon approaching RI #58, the resident was heard saying, "Please help me to get out of this chair." RI #58 was observed to place his/her hands on the armrest in an attempt to push the Geri-chair forward. EI #2 stated the Geri-chair could not be moved because it was locked in the back. EI #2 acknowledged the locked, reclined Geri-chair was a restraint. | F 604 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status. | F 636 | | 5/27/21 |

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| F 636 | Continued From page 4<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.<br>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)<br>(iii)Not less than once every 12 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, review of Resident Identifier (RI) #38's medical records and an undated document titled "Use of dashes", the facility failed to ensure RI #38's Admission and Quarterly Minimum Data Set (MDS) were complete. This | F 636 | THIS PLAN OF CORRECTION CONSTITUES A WRITTEN ALLEGATION OF SUBSTANTIAL COMPLIANCE WITH FEDERAL MEDICARE AND MEDICAID REQUIREMENTS. | |

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| F 636 | Continued From page 5<br>deficient practice affected RI #38, one of 23 sampled residents.<br><br>Findings include:<br><br>RI #38 was admitted to the facility on 11/20/2020.<br><br>RI #38's Admission MDS with an assessment reference date of 11/24/2020, indicated the following sections were not complete; a dash was present: Section C, Cognitive Patterns; Section D, Mood; Section G, Functional Status; Section GG, Functional Abilities and Goals; and the Influenza and Pneumococcal portion of Section O.<br><br>RI #38's Quarterly MDS with an assessment reference date of 2/21/2021, indicated the following sections were not complete; a dash was present: Section C, Cognitive Patterns; Section D, Mood, Section G, Functional Status; and the reason why the Influenza and Pneumococcal vaccine were not administered within Section O.<br><br>On 4/22/2021 beginning at 10:06 AM, an interview was conducted with Employee Identifier (EI) #3 and EI #4, both MDS Coordinators. Both staff acknowledged the areas of MDS were not assessed but offered no explanation other than the staff responsible did not complete it.<br><br>On 4/22/2021 at 11:40 AM, EI #4, MDS Coordinator presented the survey team with a undated documented titled, "Use of dashes," which documented " ... A dash value indicates that an item was not assessed ... ." | F 636 | 1. RI# 38 will have a quarterly assessment completed with an ARD of 5/13/21 which will include information for required sections C,D, G, and O.<br>2. This deficient practice has the potential to affect all residents in the facility. MDS Coordinators will audit sections C,D,G, GG, and O on all active residents as of 5/17/21. this will be completed by 5/21/21. The facility has taken steps listed in #3 and #4 to ensure the problem does not recur.<br>3. The Social Service Director was in-serviced on 5/13/21 by the Administrator on completing Sections C and D of the MDS (Resident Assessment and Care Screening) timely and accurately.<br>All nursing staff were in-serviced by the DON on completing ADL□s on 4/30/21.<br>The Administrator In-serviced MDS Coordinators on completion of Section GG on 5/13/21<br>The DON is in-servicing nursing staff on completion of Section GG on 5/21/21<br>The Administrator in-serviced Admission Coordinator on completing the Influenza and Pneumococcal Vaccine Record on 5/18/21.<br>The DON is in-servicing nurses on completing the Influenza and Pneumococcal Vaccine<br>Record on 5/21/21.<br>Administrator in-serviced MDS Coordinators on notifying the Administrator any time that other disciplines do not complete their sections of the MDS (Resident Assessment and Care Screening) on 5/13/21 | |

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| F 636 | Continued From page 6 | F 636 | 4. MDS Coordinators will run the ADL report X 5 days for one month, x 3 a week for the second month, and x 2 a week for the third month.This report will be given to the DON or designee for follow up to ensure continued compliance.<br>The MDS Coordinators will review all admissions for influenza and pneumococcal records for completion and inform DON and Administrator if not complete.<br>MDS Coordinators will monitor Section C and D on all assessments for completion and inform Administrator if not complete. Any non-compliance will be addressed.<br>The above monitoring is to ensure continued compliance. Any non-compliance will be addressed immediately. If compliance is not met monthly audits will continue until substantial compliance is obtained.<br>Results from audits will be discussed in our QAPI process and discussed in our monthly QAPI meetings. Findings will be reviewed in the next governing body meeting. Our next QAPI meeting will be held on May 27, 2021. | |
| F 800 SS=E | Provided Diet Meets Needs of Each Resident CFR(s): 483.60<br><br>§483.60 Food and nutrition services.<br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br>This REQUIREMENT is not met as evidenced by: | F 800 | | 5/27/21 |

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| F 800 | Continued From page 7<br>Based on observation, record review, interviews, and review of the facility policy, the facility failed to follow the recipes for pureed diets for four residents on pureed diets out of 80 residents that received food from the kitchen.<br><br>Findings include:<br><br>The facility's policy titled, "Dietary: Therapeutic Diets," dated October 2020, revealed the intent was to assure that residents received and consumed foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician.<br><br>Review of the "Diet Master" dated 4/20/2021, revealed the facility had four residents that received a pureed diet.<br><br>On 4/21/2021 at 2:40 PM, Employee Identifier (EI) #5, a dietary cook was observed to preparing the pureed entrees for the evening meal. EI #5 obtained a pan of chicken salad, which he stated had four to five servings of chicken salad in it. EI #5 poured the chicken salad into the Robot Coupe (industrialized food processor) then added an unmeasured amount of thickener and unmeasured amount of water and mixed the mixture. EI #5 added an unmeasured amount of water on three different occasions after adding the thickener. EI #5 then placed the pureed chicken salad into a pan.<br><br>On 4/21/2021 at 2:59 PM, EI #5 poured the pasta salad into the Robot Coupe, added an unmeasured amount of thickener, and then mixed the mixture. EI #5 then added an unmeasured amount of water to the mixture then blended it. EI #5 then placed the pureed pasta | F 800 | THIS PLAN OF CORREECTION CONSTITUES A WRITTEN ALLEGATION OF SUBSTANTIAL COMPLIANCE WITH FEDERAL MEDICARE AND MEDICAID REQUIREMENTS.<br>1.EI#5 was in-serviced verbally on 04/20/2021 by CDM and RD and then was in-serviced again in writing on 4/26/21 on following the recipe for pureed diets. EI#5 reviewed the policy on Dietary: Therapeutic diets on 5/12/21.<br>2.This deficient practice has the potential to affect all 4 residents that are currently on pureed diets in the facility. CDM audited through observation on 04/20/2021to ensure recipes for pureed diet was correct.<br>3.Relias training was created by RD on 05/06/2021 on pureed diets and following the recipes for pureed diets and all kitchen staff were required to complete the training by 5/14/21.<br>4.An audit tool was created by RD on 05/11/2021 on following the recipes for pureed diets. CDM or designee began completing the audit forms on May 12,2021 and will complete the audit form x 5 a week for a month, x 3 a week for the second month and x 2 a week for the third month to ensure continued compliance. Any non-compliance will be addressed immediately, and audits will continue monthly until compliance is achieved. Results from the audits will be included in our QAPI process and brought to our monthly QAPI meetings. Our next QAPI meeting will be held on Thursday, May 27,2021. | |

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| F 800 | Continued From page 8<br>salad into a pan.<br><br>Review of the recipe for the chicken salad under the puree steps documented to remove the desired number of servings and add nutritive liquid, milk, broth etc. Blend until desired consistency. Add approved thickener to achieve desired consistency if needed.<br><br>Review of the recipe for the pasta salad under the puree steps documented to remove the desired number of servings, and add nutritive liquid, milk, broth, etc. Blend until desired consistency. Add approved thickener to achieve desired consistency if needed.<br><br>On 4/21/2021 at 4:10 PM, EI #6, the Registered Dietician (RD) stated EI #5 should mix the entrée then add thickener as needed. EI #6 stated adding water would decrease the nutrients per serving. | F 800 | | |
| F 803 SS=E | Menus Meet Resident Nds/Prep in Adv/Followed<br>CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as | F 803 | | 5/27/21 |

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| F 803 | Continued From page 9 | F 803 | | |

input received from residents and resident groups;

§483.60(c)(5) Be updated periodically;

§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, interviews, and review of facility policy, the facility failed to follow the menu for scoop size of the pureed entrees for four of four residents that received a pureed diet of 80 residents that received food from the kitchen.

Findings include:

The facility's policy titled, "Dietary: Menus and Adequate Nutrition," dated October 2020, revealed the menus should be followed.

The undated facility's policy titled, "Portion Control" revealed the food should be portioned according to the current menus and portion control was achieved through using the appropriate serving utensils.

Review of the "Diet Master" revealed the facility had four residents that received a pureed diet.

On 4/21/2021 beginning at 11:00 AM, the lunch meal tray line was observed. Employee Identifier (EI) 5, a dietary cook, placed on the residents that

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1.EI #5 was informally in-serviced by CDM and RD on 4/21/21 on the proper use of scoop sizes. EI#5 was formally in-serviced on 4/26/21 on following the menu for the correct scoop sizes for pureed diets. EI#5 reviewed the policy on Dietary: Therapeutic Diets on 5/12/21.
2.This deficient practice has the potential to affect all four residents on a pureed diet in the facility. The dietary staff was observed on 4/21/21 by the CDM and RD to ensure the correct scoop sizes were used for pureed diets and found to be in compliance.
3.All kitchen staff was in-serviced on 4/26/21 by the CDM on following the menu for the correct scoop sizes for all menu items. CDM took an inventory of all scoops/ spoodles on 04/22/2021 and

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| | 015458 | A. BUILDING ______ B. WING ______ | 04/22/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AHC MILLENIUM | 5275 MILLENNIUM DRIVE HUNTSVILLE, AL 35806 |

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| F 803 | Continued From page 10<br>received a pureed diet plate, 2-2/3 ounces of pureed pork barbeque, pureed baked beans and pureed coleslaw. Review of the "Menu Spreadsheet" revealed the residents should receive three ounces of the pureed pork barbeque and four ounces of the pureed baked beans and the pureed coleslaw.<br><br>In an interview on 4/21/2021 at 12:00 PM, EI #7, the Certified Dietary Manager (CDM) stated the kitchen used three 2-2/3 ounce scoops to serve the pureed pork, baked beans and coleslaw instead of the required scoop sizes. | F 803 | found that the facility does have enough utensils to ensure proper servings sizes of all menu items.<br>4.An audit tool was created on following the menu and using the correct scoop sizes for all menu items. CDM or designee will complete the audit form x 5 a week for the first month, then x 3 a week for the second month, then x 2 a week for the third month to ensure continued compliance. Any non-compliance will be addressed immediately and audits will continue until substantial compliance is achieved. Results from the audits will be part of our QAPI process and discussed in our monthly QAPI meetings. Next QAPI meeting is scheduled for Thursday 05/27/2021. Findings will be reported to the governing body by the administrator at the next meeting. | |
| F 805<br>SS=E | Food in Form to Meet Individual Needs<br>CFR(s): 483.60(d)(3)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(3) Food prepared in a form designed to meet individual needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, interviews, and review of facility policy, the facility failed to serve food in a form designed to meet the individual needs for seven residents on a mechanically altered diet out of 80 total residents that received food from the kitchen. | F 805 | THIS PLAN OF CORRECTION CONSTITUTES A WRITTEN ALLEGATION FO SUBSTANTIAL COMPLAINCE WITH FEDERAL AND MEDICARE AND MEDICAID REQUIREMENTS.<br>1.EI#5 was in-serviced informally on | 5/27/21 |

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| F 805 | Continued From page 11<br>Findings include:<br><br>The facility's policy titled, "Dietary: Therapeutic Diets" dated October 2020, revealed the intent was to assure that residents received and consumed foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician.<br><br>The "Diet Master" dated 4/20/2021, revealed the facility had seven residents that received a mechanical soft diet.<br><br>During the lunch meal tray line observation on 4/21/2021 beginning at 11:00 AM, Employee Identifier (EI) #5, a dietary cook served regular baked beans to the residents that were on a mechanically altered soft diet. Further observation revealed the kitchen did not have mashed baked beans to serve to the residents.<br><br>The "Menu Spreadsheet" dated 4/20/2021, revealed residents that received a mechanical soft diet should receive mashed baked beans<br><br>In an interview on 4/21/2021 at 11:59 AM, EI #8, a dietary cook stated she did not realize the menu called for mashed baked beans and did not make any.<br><br>In an interview on 4/21/2021 at 12:00 PM, EI #7, the Certified Dietary Manager stated the facility did not provide mashed baked beans for the residents that received a mechanical soft diet. | F 805 | 4/21/21 by CDM and RD on following the menu spreadsheet for mechanically altered diets. On 4/26/21 EI#5 was formally in-serviced on following the menu spreadsheet on mechanically altered diets. EI #5 was in-serviced on 5/12/21 on therapeutic diets.<br>2.This deficient practice had the potential to affect seven residents on a mechanically altered diet. The Dietary Manager observed that the kitchen staff was following the menu spreadsheet for mechanically altered diets on 04/21/2021.<br>3.All dietary staff was in-serviced on 4/26/21 on following the menu spreadsheet on following mechanically altered diets. RD informally in-serviced CDM on 04/21/2021 and formally in-serviced CDM on 05/12/2021. How to correctly read the menu spreadsheet was added to the Dietary Competency Skills Checklist for all new dietary employees and current employees annually.<br>4.An audit tool was created on following the menu spreadsheet for mechanically altered diets. CDM or designee will complete the audit form x 5 a week for a month, then x 3 a week for a month, then x 2 a week for the third month to ensure continued compliance. Monitoring began 05/12/2021. Any non-compliance will be addressed immediately and audits will continue until substantial compliance has been achieved. Results from audits will be included in our QAPI process and discussed in our monthly QAPI meeting. Next QAPI meeting will be Thursday 05/27/2021. Findings will be reported to the governing body by the administrator at | |

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| F 805 | Continued From page 12 | F 805 | the next meeting. | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and review of the facility documents, the facility failed to ensure dishware was completed dried before storage; expired items were discarded; and the can opener and microwave were cleaned after use. These deficient practices had the potential to affect all residents who received food from the kitchen.<br><br>Findings include:<br><br>The facility's policy titled, "Dietary - Mechanical Dish Washing" dated October 2020, indicated, allow clean dishes to air dry completely before | F 812 | THIS PLAN OF CORRECTION CONSTITUTES A WRITTEN ALLEGATION OF SUBSTANTIAL COMPLIANCE WITH FEDERAL MEDICARE AND MEDICAID REQUIREMENTS.<br>1.On 4/20/21 dishware that was not completely dry and stored was immediately rewashed and dried before being stored by the CDM<br>On 4/20/21 all expired items were discarded and an audit performed to check for any other out of date items none | 5/27/21 |

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| F 812 | Continued From page 13<br>storing.<br><br>Review of the "Weekly Kitchen Cleaning Schedule" revealed the can opener should be cleaned after each use by the cook. The PM Aide should check the dates of items in the Reach-In Cooler.<br><br>On 4/20/2021 beginning at 9:48 AM, a brief tour of the kitchen was conducted with Employee Identifier (EI) #7, the Certified Dietary Manager (CDM). The following was observed: three steam table pans were stacked together by the stove with water between them; the can opener blade had dried debris; there were seven boxes of Thickened Dairy Drinks in the reach-in cooler with an expiration date of 4/13/2021; there was one box of Thickened Cranberry Juice with an expiration date of 3/24/2021 in the reach-in cooler; two rack of dishware (bowls, divided plates, steam table plans and coffee cups) were stored in the dish room with water between them. Also noted during the tour, the microwave had dried food debris. A dietary staff member was observed to use a rag from the sanitization bucket to clean the microwave. When the solution in the bucket was checked for the level of sanitizer in the bucket, the sanitization level could not be obtained, the CDM instructed the staff to change out the water and sanitizer in the bucket;<br><br>SUSAN DANNELS,<br>KRYSTAL ADAMS, OTHER<br>TONYA GREEN,<br>ADRIENNE JACKSON, | F 812 | were found by the CDM<br>On 4/20/21 the can opener and microwave were immediately re-cleaned by the cook.<br>2.All residents have the potential to be affected by these deficient practices. An audit was conducted by CDM on 04/20/2021 to ensure dishware was completely dry before being stored. The administrator verified that expired items were appropriately discarded and that the microwave and can opener were cleaned on 04/20/2021<br>3.Registered Dietician in-serviced the Certified Dietary Manager on 5/12/21 on sanitation including allowing dishware to dry completely before storing, checking for expired items and following our policy on cleaning the can opener and microwave following each use. The RD will do a monthly sanitation audit to ensure compliance. All kitchen employees were in-serviced on 4/26/21 on sanitation by CDM<br>4.Racks have been purchased by the CDM on 04/21/2021 to place dishware on until completely dry before being stored. New microwave was purchased on 5/11/21. Sanitation checklist will be used by CDM or designees for a monitoring tool. CDM began using this monitoring tool on 4/26/21. CDM or designee will complete the audit form x 5 a week for the first month, x 3 a week for the second month, and x 2 a week for the third month to ensure continued compliance. Any non-compliance will be addressed immediately and audits will continue until substantial compliance is achieved. | |

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| F 812 | Continued From page 14 | F 812 | Results from audits will be discussed in our QAPI process and discussed in our monthly QAPI meeting. The next QAPI meeting will be held on Thursday, May 27,2021. | |