STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155798	A. BUILDING 00 B. WING	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 7, 8, 9, 12, and 13, 2022 Facility number: 012861 Provider number: 155798 AIM number: 201080610 Census Bed Type: SNF/NF: 73 SNF: 25 Total: 98 Census Payor Type: Medicare: 25 Medicaid: 63 Other: 10 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 21, 2022.	F 0000		
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident was assessed to safely administer a topical medication related to a topical non-steroid anti-inflammatory medicated gel being left at the residents bedside for 1 of 1 residents reviewed for self medication.	F 0554	1. 1. The tube of Voltaren gel was immediately removed from the bedside of resident #89. 2. 2.All residents who have medication at the bedside without a self-administration assessment	10/07/2022

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

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	(Resident 89). During an observation on 9/7/22 at 11:52 A.M., a tube of Voltaren gel (a topical non-steroid anti-inflammatory medicated gel for pain relief) was observed on the bedside table in Resident 89's room within his reach. During an observation on 9/8/22 at 9:45 A.M., the tube of Voltaren gel was observed on the bedside table within the resident's reach. The clinical record for Resident 89 was observed on 9/9/22 at 9:29 A.M. The Minimum Data Set (MDS) assessment, dated 8/28/22, indicated the resident diagnoses included, but were not limited to, Moderate Intellectual Disabilities and generalized muscle weakness. The clinical record lacked a self-administration medication assessment for the resident. A care plan, dated 8/27/22, indicated the resident had short term memory loss with poor safety awareness and impaired decision-making skills. During an interview with Registered Nurse (RN) 9 on 9/12/22 at 2:21 P.M., she indicated residents should participate in a medication self-administration assessment prior to keeping any medications at their bedside. The residents must be able to express the desire to self-administer the medication, properly identify the medication and verbalize the physician's orders for proper administration of the medication. During an interview on 9/12/22 at 2:38 P.M., the Director of Nursing (DON) indicated that a medication self-administration assessment should have been done on Resident 89.		have the potential to be affected by the alleged deficient practice. A room-to-room audit has been completed to ensure no other medication have been left at the bedside. 3. 3.The policy on Self-Administration of Medications has been reviewed and no changes indicated at this time. Nursing staff will be educated via in person in-service that medications/treatments are not to be left at the bedside unless a self-administration assessment has been completed and deemed safe. DON/Designee will audit 5 rooms on each hallway each business day to ensure no medications are left at the bedside X 6 weeks, then 3 times weekly X6 weeks, then weekly X3 months. 4.Results will be reviewed at each Quality Assurance meeting until 100% compliance is met or until deemed compliant by QAPI review.	

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	Review of the topical non-steroid anti-inflammatory medicated gel for pain relief product insert indicated if ingested there was a risk of serious gastrointestinal events including bleeding, ulceration, and perforation of the stomach, and small intestine or large intestine. A current policy titled "Medication administration", dated 2/1/2018, was reviewed on 9/12/22 at 2:55 P.M. The policy indicated that the facility should evaluate a resident for the ability to safely administer medications independently, document any assessment, and training. 3.1-11(a)			
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §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: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.			

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	(viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (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. §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. (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.) (iii)Not less than once every 12 months. Based on interview and record review the facility failed to ensure the accuracy of the Minimum Data	F 0636	1. The inaccurate MDS for resident #-- has been modified.	10/07/2022

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	Set (MDS) assessment for 1 of 20 residents reviewed (Resident 38). Findings include: During an interview on 9/8/22 at 9:25 AM, Resident 38 indicated he had not received dialysis services. The clinical record for Resident 38 was reviewed on 9/8/22 at 9:45 AM. The quarterly MDS assessment, dated 6/9/22, indicated Resident 38 was alert and oriented. The recent 5 day Medicare assessment and quarterly MDS assessment, dated 6/9/22, indicated the resident received dialysis services. During an interview on 9/8/22 at 10:12 AM, MDS Coordinator 2 indicated an offsite employee had completed the 5 day Medicare assessment for the resident and then copied it over onto the quarterly MDS assessment. During an interview with the Director of Nursing (DON) on 9/8/22 at 11:16 AM, the DON indicated the facility did not have a specific policy for MDS assessments but followed the Resident Assessment Instrument (RAI) Manual. The RAI Manual was reviewed on 9/9/22 at 4 PM. The RAI Manual indicated "...the assessment should accurately reflect the resident's status ...identify any special treatments, procedures, and programs the resident received during the specific time periods." 3.1-31(c)(6)		2. All residents receiving dialysis services have the potential to be affected. An MDS accuracy audit will be completed for those residents and modifications completed as indicated. 3. MDS staff will be educated on Chapter 3 SECTION O of the RAI Manual for specific instructions on. The Regional Resident Coordinator or designee how to code SECTION ACCURATELY will audit 5 MDS's per week for accuracy OF O100J (DIALYSIS) for 6 weeks and until 100% accuracy is achieved, then 10 per month X5 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings until 100% compliance is met or until deemed compliant by QAPI review.	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §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; Based on observation, interview, and record review, the facility failed to cleanse a resident's hands during bathing for 1 of 3 residents reviewed for activities of daily living. (Resident 41) Findings include: During an interview on 9/9/22 at 10:04 a.m., Resident 32 indicated he received a shower or bed bath twice weekly. Staff did not wash his hands while they were during his bath. An observation on 9/9/22 at 10:05 a.m., of the resident's left hand indicated he had contractures to the left hand. A rust-colored dry flaky residue was observed between the 4th and 5th fingers of the resident's left hand. The resident's fingernails were observed to be long and curled over on both hands. The resident's clinical record was reviewed on 9/12/22 at 3:22 p.m. The resident's diagnosis included, but was not limited to, left sided paralysis from a stroke. A quarterly Minimum Data Set (MDS) assessment, dated 7/27/22, indicated the resident was alert and oriented. He required extensive assistance from staff for bathing. Review of the resident's current bathing schedule indicated he was to receive either a full bed bath or a shower on Tuesdays and Saturdays.	F 0677	1. 1.Resident #32's hand was immediately cleaned and nail care provided. 2. 2. All residents with contractures have the potential to be affected by the alleged deficient practice. A review of all residents with contractures has been completed to ensure any contracted areas are clean and fingernails trimmed. 3. 3.The policy on Contractures was reviewed and no changes were indicated. Nursing staff educated on ensuring all contractures are clean via in person in-service. DON/Designee will audit all residents with contractures after their bath days weekly to ensure contracted areas are clean and fingernails trimmed X 6 weeks, then 3 residents per week X6 weeks, then 1 resident per week X3 months. 4. Results will be reviewed at each Quality Assurance meeting until 100% compliance is met or until deemed compliant by QAPI review.	10/07/2022

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The resident's shower sheets were provided by the ADON on 9/13/22 at 10:22 a.m. The shower sheets indicated the resident received a bed bath on 8/16/22, 8/19/22, 8/26/22, 8/30/22 and 9/10/22. The resident had a shower on 9/3/22 and refused bathing on 9/6/22.

During an interview and observation on 9/13/22 at 10:34 a.m., the resident indicated he had received a bed bath that morning. A rust-colored dry, flaky residue was observed on the resident's left palm and between the 4th and 5th fingers on his left hand. A rust-colored dry, flaky residue was observed on the palm of the resident's right hand. The resident's fingernails were long and curled over on both hands. The resident indicated he would appreciate having his fingernails trimmed and no facility staff had ever offered to wash his hands or trim his fingernails.

During an interview on 9/13/22 at 10:45 a.m., the Director of Nursing (DON) indicated she was not aware of the discoloration on the resident's hands or his choice to have his fingernails trimmed. The DON observed the resident's hands and washed the resident's left palm. Rust colored dry, flaky, bits transferred to the washcloth.

A current policy titled "Personal Hygiene" ,revised on 6/21, indicated a full bath or shower was to be offered twice weekly and personal hygiene was to be performed twice daily. Hand washing was indicated as an activity included in personal hygiene.

3.1-38(a)(3)(A)
3.1-38(a)(3)(E)

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed the ensure the residents remained free of accidental hazards related to smoking for 2 of 4 residents reviewed for accident hazards. (Residents 67 and 22). 1. During an interview on 9/7/22 at 9:40 A.M., the administrator indicated that there was one current smoker in the facility. She identified the resident (Resident 22). On 9/7/22 at 4:00 PM, Resident 67 was observed in the visitor's parking lot near the rehabilitation entrance at the east side of the building. Resident 67's clinical record was reviewed on 9/8/22 at 10:24 A.M. The resident's diagnoses included, but was not limited to, morbid(severe) obesity with alveolar hypoventilation, nicotine dependence, cigarettes, uncomplicated, and asthma, unspecified. The facility had not identified Resident 67 as a current smoker. A record review was conducted on 9/8/22 at 10:24 AM. A Minimum Data Set (MDS) assessment, dated 8/16/22, indicated the resident used extensive assistance for locomotion on and off the unit. The resident was alert and oriented.	F 0689	1. 1. Smoking assessments were completed on resident #67 and resident #22 immediately. Lighters were locked up when not in use. Residents 67 and 22 no longer reside in the facility as they discharged home. 2. 2. Any resident who smokes has the potential to be affected by the alleged deficient practice. No other residents currently smoke. 3. 3.The Smoking policy was reviewed and no changes were indicated. A review of all residents was completed to ensure they are not smoking. All staff educated via in-person in-service to notify the Administrator of any residents who are observed smoking, that a smoking assessment needs to be completed and that lighters need to be locked up, followed by a care plan meeting to be conducted with resident/family. HFA/Designee to complete assessments of 5 new admissions weekly to ensure they are not smoking X6 weeks, then 3	10/07/2022

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	During an interview on 9/8/22 at 9:48 A.M., Resident 67 indicated staff assisted her to propel her wheelchair in and out of the building. She smoked independently and disposed of cigarette butts in an old cigarette pack after extinguishing them. She stored the cigarette pack with extinguished cigarettes in her bag along with her cigarettes and lighter. During an interview on 9/8/22 at 10:09 A.M., Registered Nurse (RN) 9 indicated the facility was non-smoking, but she was not sure what the resident had worked out with administration. The RN was not aware of any assessment regarding safe smoking practices being completed. The staff assisted the resident to propel her wheelchair in and out of the door only. Resident 67 was not supervised while smoking and the RN was not aware of how and where cigarette butts were discarded. During an interview with the Administrator on 9/8/22 at 11:03 A.M., the administrator indicated that she was unaware that Resident 67 was a current smoker. The Administrator indicated the resident had not been assessed for safe smoking because she was unaware that the resident was smoking. 2. On 9/8/22 at 5:00 P.M., Resident 22 was observed sitting in his wheelchair, listening to music while smoking on the north side of the facility along the curbside. A tin can was observed sitting on the curb appropriately fifteen feet from resident. During an interview on 9/8/22 at 5:00 P.M., Resident 22 indicated he disposed of cigarette butts in a tin can. The resident indicated he kept his cigarettes and lighter in his room when he was		residents weekly X6 weeks then 1 resident weekly X3 months. 4. Results of audits will be reviewed at Quality Assurance until 100% compliance is met or until deemed compliant by QAPI review.	

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	not smoking. On 9/8/22 at 11:00 A.M., Resident 22's clinical record was reviewed. The diagnoses included, but were limited to, nicotine dependence, chronic obstructive pulmonary disease, left below the knee amputation, obesity, post-traumatic stress disorder and anxiety. The quarterly Minimum Data Set (MDS) assessment, dated 7/4/22, indicated the resident was able to make himself-understood while understanding others clearly. The resident was alert and oriented. He required the assistance of two physical staff to turn side to side and position while in bed. He required the assistance of one physical staff to transfer between surfaces. The resident's care plan, last reviewed 6/28/22, indicated he smoked tobacco products currently with an intervention to ensure resident would not suffer injury while smoking. During an interview on 9/8/22 at 11:16 A.M., Licensed Practical Nurse (LPN) 2 indicated Resident 22 kept his cigarettes and lighter in his room. When the resident left the facility to smoke, he knew the code to the door key of the Rehab entrance/exit and went out on his own. During an interview on 9/7/22 at 9:40 A.M., the administrator indicated only one resident currently residing in the facility smoked. The resident was identified as Resident 22. During an interview on 9/8/22 at 11:38 A.M., the Executive Director (ED) indicated the facility was a non-smoking facility and had no policy for residents that smoked. At 12:46 A.M., the ED indicated, as a non-smoking facility, smoking assessments were not completed on residents. Cigarettes and lighters were kept with the resident			

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	that smoked. On 9/9/22 at 12:00 PM, the facility's "Indiana Admission Move-In Guide," dated 3/9/21 and E-signed by Resident 67, dated 7/21/21 and E-signed by Resident 22, were provided by the ED. The guide indicated the facility and grounds were designed tobacco free and the use of tobacco products was prohibited. No policy was provided by the facility for a resident who smoked regarding safety assessment, resident education, and the oversite of smoking equipment by conference exit. 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and			

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	nasal-pharyngeal ulcers. Based on observation, interview, and record review the facility failed to maintain proper handling of tube feeding supplies for 1 of 3 residents reviewed for tube feeding. (Resident 41). Findings include: During an observation on 9/7/22 at 3:24 p.m., there was an opened, half full bottle of tube feed formula and a bag of clear liquid hanging on a pole. There was no date or time indicated on the bottle, the bag, or the tubing. The was no indication as to the contents of the clear bag. There was no cap on the end of the tubing and a clear bag that contained a piston syringe dated 9/6/22. During an observation on 9/9/22 at 9:45 a.m., a bag containing clear liquid was dated 9/8/22 and a bag that contained a piston syringe was dated 9/9/22. There was a cap on the end of the tube feeding and 3:00 a.m. was handwritten on the tube feed formula bottle. An interview with the DON on 9/9/22 at 12:15 p.m., she indicated the tube feed supplies were changed on night shift. The bottle, tubing, and bag should always be labeled with the date, time, and nurse initials. The end of the tubing should be capped. The clinical record for Resident 41 was reviewed on 9/12/22 at 3:22 p.m. The resident's diagnoses included, but were not limited to, tongue cancer, left side paralysis from a stroke, and tube feed status. A quarterly Minimum Data Set (MDS) assessment, dated 7/27/22, indicated the resident was alert and oriented and required extensive assistance of staff for bathing.	F 0693	1. 1. Resident #41 tube feeding and H2O bag was checked and dated, timed with rate and initials. 2. 2.All residents who receive tube feedings have the potential to be affected by the alleged deficient practice. A review of all residents who receive tube feedings was completed to ensure bottles/bags dated, initialed, rate and initials and capped in not in use. 3. 3. The policy on Continuous Enteral Feeding via Pump was reviewed and no changes indicated at this time. Nursing staff in-serviced to ensure all bottles are dated, timed, rate written, initialed and capped when not in use via in-person in-service. DON/Designee to audit all residents who receive tube feedings each business day to ensure the bottles are dated, initialed, rate written, and capped if not in use X6 weeks, then 3 residents a week X6 weeks, then 1 resident a week X3 months. 4. Results will be reviewed at each Quality Assurance meetings until 100% compliance is met or until deemed compliant by QAPI review.	10/07/2022

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	A physician's order, dated 6/29/22, indicated the resident was to be administered Jevity (fiber-fortified therapeutic nutrition), 1.5 at 70 milliliters an hour, for 15 hours daily. A physician's order, dated 6/30/22, indicated the piston syringe was to be changed every night shift. A physician's order, dated 9/9/22, indicated the tube feed tubing and water bag were to be changed every night shift. A current policy, dated 7/2012 and revised 1/2019, was supplied by the DON on 9/9/22 at 12:40 p.m. The policy indicated the tube feed bottle and bag were to be labeled with the date, time, rate, and nurse initials. 3.1-44(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or			

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	§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to adequately monitor narcotic pain medication side effects for 3 of 10 residents reviewed for unnecessary medication. (Residents 15, 39, and 41) Findings include: 1. The clinical record for Resident 15 was reviewed on 9/9/22 at 2:30 p.m. The resident's diagnoses included, but were not limited to, diabetes, atrial fibrillation, bilateral hearing loss, colostomy status, and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment, date 6/23/22, indicated the resident was alert and oriented. A physician's order, dated 8/23/22, indicated the resident received morphine sulfate (narcotic), 15 milligrams extended release, administered twice daily for pain. The resident's care plan and medication administration record (MAR) did not indicate the resident was being monitored for side effects of narcotic pain medications. During an interview with the Director of Nursing (DON), on 9/12/22 at 2:54 p.m., she indicated she was unaware that narcotic pain medications were required to be monitored for side effects. She	F 0757	1. 1. The care plans were updated to include monitoring for side effects for narcotic use on residents #15, 39 and 41. 2. 2. All residents who receive narcotics have the potential to be affected by the alleged deficient practice. A review of all residents who receive narcotics was completed and care plans updated if needed to include to monitor for side effects. 3. 3. The policy is being reviewed and updated with recent CMS changes. Nursing staff in-serviced via in-person in-service to include side effect monitoring in the care plan for any narcotics. DON/Designee will review all new orders each business day to ensure all new narcotic orders have care plans to observe for side effects ongoing. 4. Results will be reviewed at Quality Assurance meetings until 100% compliance is met or until deemed compliant by QAPI review.	10/07/2022

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	would discuss the requirement with the corporate DON. 2. The clinical record for Resident 39 was reviewed on 9/9/22 at 9:26 a.m. The resident's diagnoses included, but were not limited to, unspecified intellectual disabilities, atrial fibrillation, heart failure, contractures to both legs, pain to both legs, constipation unspecified, and other artificial openings of gastrointestinal tract status (tube feeding). The comprehensive MDS assessment, dated 7/24/22, indicated the resident's cognition was mildly impaired. A physician's order, date 8/29/22, indicated the resident received oxycodone (narcotic), 10/325 milligrams, every 4 hours for chronic pain. The resident's care plan and MAR did not indicate the resident was being monitored for side effects from narcotic pain medication. During an interview with the DON, on 9/12/22 at 2:54 p.m., she indicated the resident was prone to bowel problems and had to be hospitalized for server constipation in the past. 3. The clinical record for Resident 41 was reviewed on 9/9/22 at 11:32 a.m. The resident's diagnoses included, but were not limited to, tongue cancer, left side paralysis from a stroke, and tube feed status. The quarterly MDS assessment, dated 7/27/22, indicated the resident was alert and oriented and required extensive staff assistance for bathing. A physician's order, dated 8/22/22, indicated the resident received oxycodone hydrochloride, 5 milligrams, twice daily for pain.			

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	The resident's care plan and MAR did not indicate the resident was being monitored for side effects from narcotic pain medication. A document (not dated) titled "Side Effects Monitoring" supplied by the DON, on 9/9/22 at 12:40 p.m., did not indicate that narcotics were required to be monitored for side effects. The National Institute of Health (2022) indicated side effects of narcotic pain medications include, but were not limited to sedation, confusion, slow respiratory rate, and constipation. National Institute of Health (2022). https://nida.nih.gov/publications/drugfacts/prescription-opioids. 3.1-48(a)(3)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §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.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure sanitary conditions in food service areas related to debris on dishes, the storage of wet cookware and glassware, and handwashing during food service. This deficient practice had the potential to affect 94 of 98 residents residing in the facility. 1. During an observation of the facility kitchen on 9/7/22 at 10:11 A.M., there were baking sheets and metal food storage pans were stacked. The sheets and pans were separated for inspection and were observed to be wet in all stacks of stored for food use. Clear, wet, fluid was observed between all of the stacked ready for use drinking glasses. Two plates and four bowls were observed to have pieces of black and brown debris on their surface. An interview on 9/7/22 at 10:11 A.M., the Certified Dietary Manager (CDM) indicated that all cookware and dishes should be checked for debris and air dried prior to stacking and storing. A current policy titled "Dish Machine Use" last revised 3/2022, indicated that dishes should be visually inspected during the unloading process. Dishes that are not clean should be rewashed. Dishes and glassware should be air dried and not be nested (stacked with one inside the other) until completely dry. 2. During meal service observation on 9/7/22 at 11:17 A.M., Dietary Aide 6 was observed taking two dinner plates uncovered to two different residents at the same time. After placing the	F 0812	1. 1. The dishes that were wet or noted to have debris were re cleaned and dried appropriately and Cook 5 completed handwashing immediately. 2. 2.All residents have the potential to be affected by the alleged deficient practice. 3. 3.The policy Dish Machine Use and Handwashing reviewed with no changes needed. Dietary staff in-serviced on 9-21 on handwashing and sanitation. CDM/Designee will complete safe food handling audit and audit of clean dishes will be completed 5 times per week X6 weeks, then 3 times per week X6 weeks, then weekly X3 months. 4. 4.Review of audits will be forwarded to QA meetings until 100% compliance is met or until deemed compliant by QAPI review.	10/07/2022

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	plates in front of each resident, Dietary Aide 6 picked up the silverware belonging to one resident, began cutting their meat, and then picked up the silverware of the next resident and cut their meat. The dietary aide returned to the kitchen and delivered a carafe of ice water to a different table, picked up each resident's glass and filling it with water. No hand hygiene was performed before or after any of the tasks performed. Cook 5 was observed delivering meal plates to multiple residents without performing any hand hygiene while she delivered multiple plates. An interview on 9/7/22 at 11:24 A.M., the Dietary Aide 6 indicated that staff should wash their hands before they start their day, when changing work areas, and when they are dirty. An interview on 9/7/22 at 11:27 A.M., the Certified Dietary Manager (CDM) 7 indicated that staff should be washing their hands before passing each tray and after each event where hands become contaminated. A current policy titled "Handwashing", dated 10/2017 was reviewed on 9/7/22 at 3:24 P.M. The policy indicated that employees should wash their hands when entering the kitchen, at the start of the shift, when changing tasks to prevent cross contamination, and when engaging in any other activities that contaminate the hands. 3.1-18 (b)(1)(l) 3.1-21 (i)(3)			