STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING 00 B. WING	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00437948 and IN00444117. Complaint IN00437948 - No deficiencies related to the allegations are cited. Complaint IN00444117 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: September 25, 26, 27, 30, and October 1, 2024 Facility number: 000009 Provider number: 155022 AIM number: 100274760 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 4 Medicaid: 51 Other: 2 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 3, 2024.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir			

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

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	Based on interview and record review the facility failed to accurately document a resident's code status in the clinical record for 1 of 1 resident reviewed for advanced directives (Resident 40). Findings include: The clinical record for Resident 40 was reviewed on 9/27/24 at 12:02 p.m. The resident's Indiana physician orders for scope of treatment (POST) form, dated 6/25/24, indicated the resident was to receive Cardiopulmonary Resuscitation (CPR) in the event the resident had no pulse and was not breathing. The form was signed by Resident 40 and the physician. The physician recapitulation (recap) orders for Resident 40, dated 9/2024, indicated the resident was not to be resuscitated in the event the resident had no pulse and was not breathing. Review of the record of Resident 40, on 9/30/24 at 1:44 p.m., indicated the diagnoses included, but were not limited to, cerebral palsy, hypertension, anxiety, anemia, atrial fibrillation, and major depressive disorder. During an interview with the Director of Nursing (DON) on 9/30/24 at 1:58 p.m., indicated Social Services had an ongoing binder with the POST forms. Medical records were responsible to ensure that the POST form and physician orders matched. During an interview with the Social Service Director on 9/30/24 at 2:02 p.m., indicated Social Services did not have an ongoing binder with residents' current code status. During an interview with the DON on 10/1/24 at 10:13 a.m., indicated what she believed happened	F 0578	1. Resident continues to reside at the facility and remains a DNR. 2. Medical Records scanned in correct POST form to the medical record indicating DNR status during the survey and a copy was provided to the surveyors for resident 40. Incorrect POST form was deleted from the clinical record during the survey. 1. All residents have the potential to be affected. 2. DON/designee completed facility wide audit for all residents to verify code status order matches POST form on/by 10/25/24. 1. DON/designee educated nursing staff on Communication of Code Status policy on/by 10/25/24. 2. DON/designee will review code status/POST forms 5x/week in daily clinical meetings for all new admissions. 3. DON/designee will audit code status orders/POST forms randomly weekly x4 weeks then monthly x6 months to ensure physician orders match POST form. 1. All results and audits will be reviewed by the QA Committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	10/25/2024

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	was when Resident 40 was readmitted back to the facility, on 6/25/24, the floor nurse had the resident sign the POST form without explaining to him what it really meant. The communication of code status policy provided by the DON, on 10/1/24 at 10:15 a.m., indicated the facility would adhere to the resident's right to formulate advanced directives and the facility would implement procedures to communicate a resident's code status to those individuals who needed to know this information. The nurse who notates the physician order was responsible for documenting the directions in all relevant sections of the medical record. The Social Services Director shall maintain a list of residents who have Advanced Directives on file. 3.1-4(f)(4)(A)(ii) 3.1-4(f)(5) 3.1-4(f)(7)		IDR for F578 The facility provided accurate and original POST form during the survey. Resident was admitted to the facility on 10/27/22 and remained a resident through 5/30/24. Resident was a DNR for length of stay. Resident transferred to another ECF from 5/30/24 through 6/24/24 where he remained and DNR. Admitted back to the facility on 6/24/24 with written physician orders for DNR. Medication reconciliation was completed on the next business day by DON/clinical staff and noted the discrepancy on the POST form. A new form was completed with the resident and physician signature indicating the resident was to be a DNR. Original POST was provided from the active medical record. Physican orders and care plan both accurate with DNR status during time of survey.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to encode minimum data set (MDS) assessments accurately for 2 of 2 residents reviewed for MDS accuracy. (Resident 44 and Resident 53) Findings include: 1. The clinical record for Resident 44 was reviewed	F 0641	1. Resident 44 continues to reside at the facility and remains on Hospice. 2. Resident 53 continues to reside at the facility and remains on Aspirin. 3. Resident 44 assessment was modified by the MDS coordinator from quarterly assessment 6/10/24.	10/25/2024

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	on 10/1/2024 at 11:00 a.m. The medical diagnoses included benign neoplasm of cerebral meninges (layers of membranous connective tissue that cover and protect the brain and spinal cord). A Quarterly MDS assessment, dated 9/4/2024, indicated Resident 44 had a six month or less life expectancy, but did not receive hospice services. A hospice plan of care, dated 6/20/2024, indicated Resident 44 was admitted to hospice on 7/31/2023. During an interview, on 10/1/2024 at 12:00 p.m., the MDS Coordinator indicated Resident 44 was admitted on hospice care, had received hospice services continuously since admission, and the, 9/4/2024, MDS assessment was coded inaccurately. 2. The clinical record for Resident 53 was reviewed on 9/30/2024 at 1:03 p.m. The medical diagnoses included dementia. An Admission MDS assessment, dated 8/13/2024, indicated Resident 53 received an anticoagulant medication in the seven days prior to the admission reference date. The physician orders, provided by the facility on 10/1/2024 at 1:00 p.m., for Resident 53 did not include an order for anticoagulant medication. During an interview with the MDS Coordinator, on 10/1/2024 at 12:00 p.m., they indicated Resident 53 had not been on an anticoagulant during the review period of the Admission MDS assessment, on 8/13/2024, and the assessment was coded in error. The facility's expectation was to code the MDS assessments to the most recent standards set forth in the Resident Assessment Instrument		4. Resident 53 assessment was modified by the MDS coordinator from quarterly assessment 8/13/24. 1. All residents receiving Hospice services or Aspirin have the potential to be affected. 2. Facility wide audit completed on 10/4/24 for all residents receiving Hospice services or Aspirin. Assessment modifications completed for those assessments found to be out of compliance. 1. Administrator educated MDS coordinator on Conducting an Accurate Resident Assessment policy on/by 10/25/24. 2. MDS coordinator will complete random audits for Hospice services and/or Aspirin therapy weekly x4 weeks them monthly x6 months. 1. All results will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved. ="" span="">"> /p> /p>	

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	Manual. A policy entitled, "Conducting an Accurate Resident Assessment", was provided by the DON on 10/1/2024 at 1:00 p.m. The policy indicated, "The purpose of this policy is to assure that all residents receive an accurate assessment..."			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review the facility failed to conduct care plan meetings for 1 of 4 residents reviewed for care plans. (Resident 10) Findings include: The clinical record for Resident 10 was reviewed on 9/30/24 at 11:02 a.m. The diagnoses included, but were not limited to, Parkinson's disease, chronic obstructive pulmonary disease, and major depressive disorder. During an interview with Resident 10 on 9/26/24 at 12:17 p.m., indicated they did not recall having care plan meetings. The Quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated Resident 10 was cognitively intact. The EHR (electronic health record) indicated Resident 10 had a comprehensive care plan meeting, on 12/14/23, with no further care plan meetings held until 7/1/24. During an interview with the Social Service Director (SSD) on 10/1/24 at 12:30 p.m., indicated he was unable to find where Resident 10 had a	F 0657	A What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident 10 continues to reside at the facility. 2. Care Conference was held on 10/10/24 with resident in attendance. B How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected. 2. SSD to complete facility wide audit on/by 10/25/24 to ensure all residents are in compliance with quarterly care conference meetings. C What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	10/25/2024

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	care plan meeting. The SSD indicated social services were responsible to set up care plan meetings and meetings were conducted quarterly and as needed. A Comprehensive Care Plan policy was provided by the Director of Nursing on 10/1/24 at 1:10 p.m. The policy indicated, "...This facility supports the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care)...10. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan...." 3.1-35(d)(2)(B)		recur. 1. Administrator educated SSD on Comprehensive Care Plan policy on/by 10/25/24. 2. SSD will complete random audits for quarterly care conference meetings weekly x4 weeks then monthly x6 months to ensure meetings are being held timely. D How the corrective actions will be monitored to ensure the deficient practice will not recur. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure neurological checks, that included vital signs, were fully conducted for a resident who experienced an unwitnessed fall for 1 of 4 residents reviewed for accidents. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/27/24 at 10:00 a.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, hypertension, anxiety, weakness, and repeated falls.	F 0684	A What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident B no longer resides at the facility. B How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents with unwitnessed	10/25/2024

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	An Admission Minimum Data Set (MDS) assessment, dated 5/24/24, indicated moderate cognitive impairment, impairment to one side of the lower extremity, and substantial/maximal assistance with bathing, toileting, and personal hygiene. Resident B had a history of falls prior to admission to the facility and one fall since admission to the facility. A fall care plan, last revised on 8/5/24, indicated Resident B had a history of falls and required assistance from at least one staff member for safe transfers. The interventions included, but were not limited to, observe for and report changes in mobility and/or range of motion. A health status note, dated 8/2/24 at 11:44 p.m., indicated the following, " ...Res [Resident B] fell in bathroom and QMA [qualified medication aide] found her on the floor. 2 skin tears received, one on left wrist and one on left leg. Cleaned, non-stick dressing applied and kerlix applied. Family and NP [Nurse Practitioner] notified ...." A document, dated 8/2/24, indicated Resident B had an unwitnessed fall on 8/2/24 at 11:00 p.m. Resident B was laying on her left side with oxygen in place and was incontinent of bowel. There was a skin tear to the left wrist and the left leg. Resident B was documented as being alert to person only, had gait imbalance, and impaired memory. The family member and nurse practitioner were notified. The document was indicative as not being a part of the clinical record. The next consecutive health status note, dated 8/3/24 at 9:15 p.m., indicated the following, " ...Hoted [sic; Noted] left arm and leg appears weaker. Left hand grip is good. Left leg with poor weight bearing. Denied pain/discomfort. Alert per		falls have the potential to be affected. 2. Neurological assessments will be completed with all unwitnessed falls or any injury that requires assessment per the facility policy. C What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DON/designee educated nursing staff on Fall Management policy on/by 10/25/24. 2. DON/designee will audit all neurological assessments for completion 5x/week in daily clinical meeting for accuracy and completion. 3. DON/designee will complete random audits for completion of neurological assessments weekly x4 weeks then monthly x6 months. D How the corrective actions will be monitored to ensure the deficient practice will not recur. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved	

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	baseline. Son poa [power of attorney] [name of POA] informed ...." A fall follow up document, dated 8/3/24, indicated not applicable for documentation of physician and/or family notification, a head-to-toe assessment was completed, no new injury was discovered, and vital signs were documented, as obtained, on 8/3/24 at 9:14 p.m. A document titled "Neuro Assessment", initiation date of 8/2/24, indicated neurological checks were being conducted after Resident B exhibited the fall on 8/2/24. The document indicated to conduct neurological checks every 15 minutes four times, every 30 minutes two times, every hour two times, every four hours five times, and every eight hours six times. The following was noted: - 8/3/24 at 6:45 p.m. included vital signs, pupil response, pain response, hand grasp, level of consciousness, and motor response, - 8/3/24 at 10:45 p.m. was left blank, and - 8/4/24 at 6:45 a.m. listed Resident B being at the hospital. A fall follow up document, dated 8/4/24, indicated to document physician and/or family notification was left blank, neurological checks continued, a head-to-toe assessment was completed, no new injury was discovered, and vital signs were documented, as the most recent, dated 8/3/24 at 9:14 p.m. There were no vital signs recorded for Resident B after 8/3/24 at 9:14 p.m., in the electronic health record. The next consecutive health status note, dated 8/4/24 at 8:25 a.m., indicated Resident B was sent			

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	to the hospital due to being unresponsive. The family and nurse practitioner were notified. A policy titled "Fall Management", dated August 1, 2023, was provided by the Director of Nursing on 10/1/24 at 10:15 a.m. The policy indicated, "...Post fall...A neurological assessment will be initiated on all un-witnessed falls and or resident with suspected head injuries every 15 minutes/x4 [times 4] = [equal] (1 hour), then every 30 min/x2 [every 30 minutes two times] = (1 hour), then every 1 hour x2 = (2 hour), then every 4 hours x 5, and lastly every 8 hours x 6...This information will be found on (paper) Neuro Assessment...2. If there are no injuries, notify the physician during normal business hours...5. Fall follow up assessment will be completed and documented by licensed nurse every shift x 72 hours...." This citation relates to Complaint IN00444117. 3.1-37(a)			
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia Based on observation, interview, and record review, the facility failed to redirect residents with wandering behaviors from other residents' rooms resulting in a lack of privacy for other residents for 5 of 8 residents reviewed for dementia care. (Residents 4, 22, 24, 27, 41, 157, 159) Findings include: 1. The clinical record for Resident 22 was reviewed on 10/1/24 at 1:10 p.m. The diagnoses included, but were not limited to, dementia. She resided on the memory care unit of the facility.	F 0744	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident 22 continues to reside at the facility on the dementia unit. Redirection is successful with wandering and resident participates in structured activities on and off of the unit with staff supervision. 2. Resident 41 continues to reside at the facility on the dementia unit.	10/25/2024

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	The 6/16/24 care plan indicated she had alteration in mood and/or behavioral status related to depression, elopement risk, wanders, and history of hallucinations. Three of the five goals were for her to exhibit fewer episodes of physical/verbal behaviors toward others; to be accepting of redirection from triggered episodes of behavioral disturbances; and to be easily redirected and free from injury/adverse outcome related to wandering. Two of the interventions were to assist her with developing coping techniques that diminish/alleviate physical/verbal behaviors toward others and to redirect her from confrontational interactions as necessary. There was no intervention to intervene as necessary to protect the rights and safety of others. 2. The clinical record for Resident 41 was reviewed on 10/1/24 at 1:08 p.m. The diagnoses included, but were not limited to, Alzheimer's disease and anxiety. She resided on the memory care unit of the facility. The 6/10/24 care plan, revised 8/29/24, indicated she had the behavior of intrusive wandering and taking things that did not belong to her. The goal was for her to decrease this behavior. One of the interventions was to intervene as necessary to protect the rights and safety of others; to approach/speak in a calm manner; divert attention; and remove from the situation and take to an alternate location as needed, effective 6/10/24. Another intervention was to provide a program of activities that was of interest and accommodated the resident's status, effective 8/29/24. 3. The clinical record for Resident 27 was reviewed on 10/1/24 at 1:08 p.m. The diagnoses		Redirection is successful with wandering and resident participates in structured activities on and off of the unit with staff supervision. 3. Resident 27 continues to reside at the facility on the dementia unit. Redirection is successful with wandering and resident participates in structured activities on and off of the unit with staff supervision. 4. Resident 157 continues to reside at the facility. A Velcro stop sign was placed on resident's door and care plan was revised and updated as warranted. 5. Resident 159 continues to reside at the facility. A Velcro stop sign was placed on resident's door and care plan was revised and updated as warranted. B How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents residing on the dementia unit have the potential to be affected. 2. Residents will continue to be re-directed when wandering in/out of rooms. 3. Activities to be conducted according to the activity calendar. 4. Activities to hire a FT activity assistant dedicated to the	

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	included, but were not limited to, Alzheimer's disease, psychotic disorder with delusions, and bipolar disorder. She resided on the memory care unit of the facility. The 6/10/24 care plan indicated she had the behavior of intrusive wandering in other residents' rooms and pushing objects/staff to get what she wanted. The goal was for her to have no evidence of behavior problems of intrusive wandering or pushing objects/staff to get what she wanted. One of the interventions was to intervene as necessary to protect the rights and safety of others; to approach/speak in a calm manner; divert attention; and remove from the situation and take to an alternate location as needed, effective 6/10/24. Another intervention was to provide a program of activities that was of interest and accommodated resident's status, effective 6/10/24 An observation was conducted on 9/26/24 at 12:26 p.m., Resident 27 was wandering down the hallway and went into an empty room, where she fiddled with the bedside table and bed. No staff intervened to redirect her out of the room, and there were no structured activities on the unit at that time. On 9/26/24 at 12:04 p.m., an interview was conducted with Resident 157, who was admitted to the memory care unit of the facility, on 9/9/24, and her husband was in her room. There was no stop sign for Resident 157's doorway, and there were no structured activities occurring on the unit at that time. Her husband indicated there were two or three different female residents who came in Resident 157's room uninvited and went through her drawers. Some of Resident 157's things went missing. None of the residents were aggressive		dementia unit. C What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DON/designee educated nursing staff on Elopements and Wandering Residents policy and Dementia Care policy on/by 10/25/24. 2. Administrator/designee will complete random audits for scheduled activities/redirection of wandering residents weekly x4 weeks then monthly x6 months. 3. Administrator/designee will complete audits of stop sign placement weekly x4 weeks then monthly x6 months. D How the corrective actions will be monitored to ensure the deficient practice will not recur. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	

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WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

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	with Resident 157, that he knew of, but he worried about Resident 157 at night when he wasn't there, that one of them may "come in and whack her." An interview was conducted with Resident 157 and her husband in her room on 10/1/24 at 12:10 p.m. There were no structured activities occurring on the unit at this time. Resident 157 indicated the residents who entered her room uninvited came in and out quickly. One, or two, of them would touch her things and it bothered her. Resident 157's husband described Resident 22 as one of the residents who came in Resident 157's room uninvited, at least 15 to 20 times over the past week. Staff did not intervene any of those times, as he was the one who would direct her out of the room, and staff never discussed use of a stop sign in the doorway with them. On 9/30/24 at 2:15 p.m., an interview and observation were conducted with Resident 159, who was admitted to the memory care unit of the facility, on 9/27/24, in her room. During this interview, Resident 22 came into the room holding a cup with a red liquid inside. Resident 22 was repeatedly making statements such as okay, "gotta go", going home, excuse me, etc. After leaving the room, Resident 22 went into the room across the hall, then came back into Resident 159's room, but this time she no longer had the cup she was holding. She left the room a second time, then came back into the room a third time. The third time, Resident 22 walked over to Resident 159's bed, touched her pillows and bedspread, and moved things around on Resident 159's bedside table. No staff came to intervene during any of these observations. Resident 159 indicated Resident 22 coming into her room bothered her, because she didn't know her. She stated, "Ain't that sad? It's always her, four to five times a day. I			

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	don't know what to say to her... just makes me nervous." There was no stop sign for Resident 159's doorway, and there were no structured activities occurring on the unit at that time. An interview was conducted with Licensed Practical Nurse (LPN) 5 on 9/30/24 at 1:55 p.m. She indicated she worked second shift starting at 2:00 p.m. and left at 10:30 p.m. Resident 27 sometimes wandered into other residents' rooms. When she did, LPN 5 tried to redirect her. LPN 5 turned on music, gave her a snack, or danced a bit. Staff tried to keep Resident 27 in the common area until after residents ate their meals. An interview was conducted with LPN 4 on 10/1/24 at 12:20 p.m. There were no structured activities occurring on the unit at that time. She indicated some of the more alert residents, like Resident 24 and Resident 4, have complained to her about residents coming into their rooms. If staff saw it, they took them out of the room and brought them to an activity or gave them a snack. They used stop signs in the past for a resident who no longer resided on the unit, and it helped some. It was usually Resident 22 and Resident 41 who went into other residents' rooms. An interview and observation were conducted with LPN 4, on 10/1/24 at 1:21 p.m., at the nurse's station. During this interview, Resident 22 approached the nurse's desk and asked where to go, stated that she wanted to get going, and didn't know what to do. LPN 4 indicated they didn't currently have a regularly scheduled activity staff person for the unit. They used to have one, but they recently stopped working at the facility, so there were no routine activities scheduled right now. When there were activities, it was things like ball toss, balloon toss, or bubbles in the			

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	courtyard. Indoor activities were things like coloring, nails, bingo, card games, cooking activities, decorating cupcakes, etc. Resident 22, Resident 41, and Resident 27 would all participate, but Resident 22 was harder to stay focused. The Elopements and Wandering Residents policy was provided by the Director of Nursing (DON) on 10/1/24 at 10:15 a.m. It read, "This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk...Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering...c. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly." The Dementia Care policy was provided by the DON on 10/1/24 at 10:38 a.m. It read, "1. The facility will assess, develop, and implement care plans through an interdisciplinary team (IDT) approach that includes the resident, their family, and/or resident representative, to the extent possible. 2. The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals....4. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's			

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	dignity, autonomy, privacy, socialization, independence, choice, and safety. 5. Individualized, non-pharmacological approaches to care will be utilized to include meaningful activities aimed at enhancing the resident's well-being." 3.1-37(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to store food and silverware properly and wear hair restraints in the kitchen. This had the potential to affect 57 of 57 residents in the facility. Findings include: A tour of the kitchen was conducted with the DS (Dietary Supervisor) on 9/25/24 at 11:15 a.m. Interviews were conducted with the DS at that time. During the tour, an observation of the clean dish racks was made. The silverware was stored in a cylindrical container with the handles facing downward, instead of upward. During the tour, an observation of the dry storage room was made. Masking tape was used to keep an opened package of vanilla wafers, an opened package of vanilla milk shake thickener, and opened package of graham cracker crumbs sealed, but the tape was no longer sticking. There were three bottles of syrup on a rack with opened tops and no lids, exposing the syrup to air. The DS indicated the opened packages of vanilla wafers,	F 0812	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Silverware was re-washed and stored correctly at the time of observation. 2. Dry storage items of vanilla wafers, thickeners, and graham crackers were sealed with saran wrap at the time of observation and tape was removed. 3. Syrup bottles were disposed of at the time of observation. Syrup will be ordered and served in single use packets on/by 10/25/24. 4. Celery was re-packaged and sealed at the time of observation. 5. Cook 5 will receive written disciplinary action on/by 10/25/24 and was educated at the time of observation. 6. Cobwebs and debris were removed from the sprinkler heads, stove hoods, and ceiling light fixtures at the time of observation	10/25/2024

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	graham cracker crumbs, vanilla milk shake thickener, and bottles of syrup with no lids could have saran wrap used to keep them sealed. During the tour, an observation of the walk-in cooler was made. There was an opened bag of celery on a shelf with the celery sticking out of the bag and resting directly on the shelf. During the tour, an observation of and interview with Cook 5 near the steam table was made. He just finished serving the lunch meal and was not wearing a beard cover over his beard. Cook 5 indicated he normally wore one, but he took it off, because they were done serving. During the tour, an observation of the stove hood was made. There was a large cobweb strung from the front of the stove hood to the back of the stove hood, and there was fuzzy debris hanging from the sprinkler heads. The DS indicated there was a company that was supposed to come to clean the stove hood, on 9/19/24, but they didn't come. During the tour, an observation of the food preparation counters in the back of the kitchen was made. There was debris hanging from the ceiling area surrounding a vent, over the food preparation counters. The ceiling light fixtures over the food preparation counters had a thick amount of debris on the ends of the light covers. Some of the light covers had dead insects resting in them. The DS indicated when they tried to clean the ceiling, parts of the ceiling would flake off. The DS was unsure about cleaning of the light fixtures. On 10/1/24 at 10:15 a.m., the Director of Nursing (DON) provided the Dietary Employee Cleanliness		B How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected. 2. Dietary Manager to receive written disciplinary action related to silverware storage, dry/cold food storage, and cleanliness of kitchen areas of sprinkler heads, stove hoods, and ceiling light fixtures on/by 10/25/24. 3. Cleaning schedule will be updated and verified by on/by 10/25/24. C What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Dietary Manager/designee educated food services department on Dietary Employee Cleanliness and Dress Code policy, General Storage Policy, and Cleaning Equipment Policy and Procedures on/by 10/25/24. 2. Dietary Manager/designee will complete random audits for correctly stored silverware 5x/week x4 weeks, then 3x/week x4 weeks, then weekly x4 weeks, then monthly x6 months. 3. Dietary Manager/designee will	

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	and Dress Code Policy. It read, "Hair restraints shall be worn in a way that effectively keeps hair from contracting [sic] exposed food, clean equipment, utensils, linens and unwrapped single-use articles." On 10/1/24 at 10:15 a.m., the DON provided the General Storage Policy. It read, "Dishes and Utensils 1.) Spoons, knives, and forks shall be stored in containers with handles upward." On 10/1/24 at 10:15 a.m., the DON provided the Cleaning Equipment Policy and Procedures. It read, "Food Prep Areas/Dish Machine/3 Compartment Sink/All Counters/Garbage Disposal: All the areas listed above are to be kept free from dirt and germs." 3.1-21(i)(3)		complete random audits for correct dry/cold food storage 5x/week x4 weeks, then 3x/week x4 weeks, then weekly x4 weeks, then monthly x6 months. 4. Dietary Manager/designee will complete random audits for hair/beard coverings. 5x/week x4 weeks, then 3x/week x4 weeks, then weekly x4 weeks, then monthly x6 months. 5. Dietary Manager/designee will complete daily cleaning schedule for stove hood, light fixtures, and sprinkler heads and complete random audits of cleanliness 5x/week x4 weeks, then 3x/week x4 weeks, then weekly x4 weeks, then monthly x6 months. D How the corrective actions will be monitored to ensure the deficient practice will not recur. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview, and record review, the facility failed to maintain the kitchen in a cleanly manner and in good repair for the potential to affect 57 of 57 residents in the facility.	F 0921	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. 1. Maintenance to replace baseboard behind ice chest on in	10/25/2024

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	Findings include: A tour of the kitchen was conducted with the DS (Dietary Supervisor) on 9/25/24 at 11:15 a.m. Interviews were conducted with the DS at that time. The wall behind the ice chest was missing baseboard. There was a cracked wall corner cover by the handwashing sink. The dishwasher counter area had four missing tiles underneath it. There was one missing tile underneath the three-compartment sink. The dry storage room had a significant amount of dirt and debris, including macaroni, on the floor against the baseboards underneath the food storage racks. The baseboard under the racks was peeling away from the wall in the corner. There was a solidified brown liquid substance on the floor underneath one of the racks. The DS indicated the brown substance may have been from previous banana boxes. The walk-in cooler had spills all over the floor. The DS indicated one area on the floor may have been old rust with liquid over it. There were cracked and missing floor tiles underneath the steamer. There were three missing tiles directly in front of the back kitchen door. On 9/25/24 at 12:15 p.m., the DS provided the, August 2024 to present, weekly kitchen cleaning logs. The weekly cleaning logs for 8/28/24 to 9/3/24, 9/4/24 to 9/10/24, 9/11/24 to 9/17/24, and 9/18/24 to 9/24/24 were not signed off as having the following areas cleaned: walls and baseboards from the walk in cooler to around the back door; both prep tables in back area-bottom, wall, baseboard, drawers, and legs; the cook's help table on serving line; the walls and baseboards behind all dish carts on clean side of dish area; and the refrigerator/freezer next to the sink. The weekly kitchen cleaning logs for the first three weeks of August 2024 were missing.		dry storage room on/by 10/25/24. 2. Maintenance to repair cracked wall corner cover by handwashing sink on/by 10/25/24. 3. Maintenance supervisor replaced 4 missing tiles under dishwasher and 3 missing tiles in front of the back kitchen door at the time of observation. 4. Maintenance supervisor to replace missing tile under 3-compartment sink and underneath the steamer on/by 10/25/24. 5. Dietary Manager completed deep cleaning in dry storage area at the time of observation. B How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All residents have the potential to be affected. 2. Dietary manager will receive written disciplinary action in relation to general maintenance and cleanliness of kitchen. C What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. Dietary Manager/designee educated food services department on Cleaning	

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	Cleaning Equipment Policy and Procedures were provided by the Director of Nursing on 10/1/24 at 10:15 a.m. It read, "Walk-In Refrigerator ...Floor is to be swept and mopped at least once a week. The racks are to be removed and the floors and walls scrubbed with sanitizing agent at least once a year..." 3.1-19(f)		Equipment Policy on/by 10/25/24. 2. Dietary Manager/designee will complete random audits for weekly cleaning logs and verify areas cleaned 5x/week x4 weeks, then 3x/week x4 weeks, then weekly x4 weeks, then monthly x6 months. 3. Dietary Manager/designee will complete weekly audits for general repair and maintenance needs (missing tiles, cracked walls, etc.) weekly x4 weekly then monthly x6 months. D How the corrective actions will be monitored to ensure the deficient practice will not recur. All results and audits will be reviewed by the QA committee monthly x6 months for substantial compliance and ongoing until 100% compliance is achieved.	