STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 00 B. WING	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 8, 9, 12, 13, and 14, 2022. Facility number: 000243 Provider number: 155352 AIM number: 100289830 Census Bed Type: SNF/NF: 52 SNF: 1 Total: 53 Census Payor Type: Medicare: 1 Medicaid: 45 Other: 7 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/21/22.	F 0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before October 7th, 2022.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview and record review, the facility failed to develop and implement a person centered care plan on a residents skin condition of bruises and abrasions for 1 out of 21 records reviewed for care plans. (Resident 46)	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All new skin areas evaluated by IDT have been discussed by DNS	10/07/2022

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	Finding includes: A clinical record review was completed on 9/12/2022 at 11:22 A.M., for resident 46 and indicated his diagnoses included, but were not limited to: cerebral amyloid angiopathy, dementia without behavioral disturbances, hypertension, type II diabetes, depressive disorder, and benign prostatic hyperplasia. Wound Management forms were filled out for 4 areas dated, 8/19/2022,and indicated that Resident 46 obtained bruises to his right forehead and upper lip and abrasions to his right hand, left elbow and shoulder. Physician Orders, dated 8/19/2022, indicated cleanse left shoulder abrasion, pat dry, apply skin prep, and cover with border gauze once a day; cleanse left elbow abrasion with wound cleanse or nirmal saline, pat dry, apply skin prep, and cover with a bandaid; and cleanse right hand abrasion with wound cleanse or normal saline, pat dry, apply skin prep, and cover with a bandaid. During an interview, on 9/12/2022 at 12:11 P.M., the Director of Nursing indicated that there was no care plan for these skin conditions and they do not do care plans for skin areas that will heal within 7-14 days. On 9/12/2022 at 2:04 P.M., the Director of Nursing indicated they should have had care plans for his skin issues. On 9/14/2022 at 1:23 P.M., the Director of Nursing provided a policy titled, "IDT Comprehensive Care Plan Policy", revised on 10/2019, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: It		or designee and MDS and careplans/temporary careplans are being put in place for all new areas. **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;** All residents with new skin areas have the potential to be affected by the deficient practice.. IDT team has been educated on importance of opening person-centered careplans/temporary careplans for all new skin areas. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** IDT team educated on importance of opening person-centered careplans/temporary careplans for all new skin areas. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** DNS/designee will check all new skins have a careplan/temporary	

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	is the policy of this facility that each resident will have a comprehensive person-centered care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific, interventions based on resident needs and preferences to promote the resident's highest level of functioning including medical, nursing, mental and psychosocial needs. Procedure: Care plan problems, goals, and interventions will be updated based on changes in resident assessment condition, resident preferences or family input...." 3.1-35(a)		careplan in place the following **business** day after the new skin occurred. QAPI tool **will be utilized during** clinical meeting daily x 4 weeks to ensure careplans are in place for all new skin issues, then weekly for 3 months. Deficiencies corrected by 10/7/22	
F 0677 SS=E 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, record review and interviews, the facility failed to ensure 9 residents were assisted to eat during 4 of 4 meal observations. (Residents 36 27 35, 47, 13, 30, 4, 37, and 34) In addiction, the facility failed to ensure fingernails were cleaned and trimmed for 1 of 3 residents reviewed for Assistance with Daily Living (Resident 34) Findings include: During an observation of the noon meal, conducted on 9/8/2022 at 12:00 P.M., the following was noted: Resident 36 was observed eating pureed food with her fingers. Nursing staff cued her once to utilize her silverware and she did for approximately	F 0677	**F677-E** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All clinical staff educated on providing assistance to assist residents with eating/cuing during meal services. DNS/designee provided nail care to all residents in building to ensure all residents fingernails were cleaned and trimmed. ADNS/designee will audit all shower sheets every business day to ensure showers are being given. **How other residents having the**	10/07/2022

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	4 bites but then put her spoon down, drank from a glass and then reverted to scooping pureed food with her fingers and licking it off her fingers. Although multiple nursing staff members walked by Resident 36 as she ate, no other staff member attempted to assist her to utilize her silverware. Resident 37's meal tray was placed on the dining table in front of him and no staff sat to assist him for over 4 minutes. Resident 34 was not pushed up to the table and was observed to be eating her food with her fingers. During an observation of the noon meal, conducted on 9/12/2022 at 12:00 P.M., the following was noted: Resident 36 was observed seated at a dining table close to the hallway. Resident 36's tray was delivered to her and set up on the table in front of her at 12:20` P.M. Resident 36 made several attempts to dip her spoon into her rolled up napkin before locating her dessert bowl. After taking a few bites of her pureed fruit with her spoon, Resident 36 set her spoon down and then attempted to drink her pureed fruit from her bowl then dropped her napkin and ice cream type dessert onto the floor. At 12:28 P.M., the Administrator stopped, picked up the napkin and ice cream dessert container and handed Resident 36 her spoon and offered her a clothing protector. At 12:33 P.M., a nursing staff member put Resident 36's spoon in her hands, placed a new opened ice cream dessert container on the table in front of the resident and placed an empty chair beside the resident, but did not sit down in the chair until 12:37 P.M. The nursing staff member		**potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents who reside in the facility have the potential to be affected by the deficient practice. All clinical staff educated on providing assistance to assist residents with eating/cuing during meal services, and all clinical staff educated on importance of providing nail care to all residents to ensure all resident fingernails are cleaned and trimmed, and all clinical staff educated on providing residents with their showers per resident preference. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All clinical staff educated on providing assistance to assist residents with eating/cuing during meal services, and all clinical staff educated on importance of providing nail care to all residents to ensure all resident fingernails are cleaned and trimmed **during showers and prn**, and all clinical staff educated on providing residents with their showers per resident preference. Non-compliance with education to result in disciplinary action up to and including termination. **How the corrective action(s) will be monitored to ensure the**	

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	started to feed Resident 36, but the resident knocked her beverage glass and the ice cream dessert container onto the floor. The nursing staff member then left the resident and later returned to mop the floor. Resident 36 had reverted to eating her pureed food with her fingers. At 12:40 P.M., the resident, while continuing to eat her pureed food from her plate with her fingers, was noted to knock the second ice cream dessert container onto the floor. Nursing staff again replaced the ice cream dessert with a new container, opened it but did not provide any assistance for Resident 36. At 12:49 P.M., Resident 36 was observed attempting to scoop out the ice cream dessert with her fingers and lick the ice cream off her fingers. No staff was providing consistent cues and/or assistance. At 12:53 P.M., Resident 27 was observed licking ice cream out of a plastic bowl. There were multiple staff walking behind her and located in the dining room, but no staff attempted to cue or assist the resident to utilize her silverware. At 12:54 P.M., Resident 34 was observed eating her food with her fingers. There were no staff observed to attempt to cue and/or assist the resident with her meal. She was also noted to be away from the table and had to extend her arms to reach her plate of food. At 12:54 P.M., Resident 35 was observed seated in the attached "sunroom" section of the dining room. Although his food was in front of him in separate bowls, he was not eating his food. When Resident 35 was queried as to why he was not eating, he indicated he could not find his fork. His fork was noted to be on the table in between		**deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** DNS/designee will complete the QAPI tools for assisting/cueing residents during meal services, Nail care, and showers, weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 10/7/22	

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	his food bowls. There was no staff noted to attempt to cue and/or assist Resident 35 with his meal. At 12:54 P.M., Resident 47 was observed seated in his wheelchair in front of the dining table. His food was on the table in front of him and he was not eating. There was no staff noted to be assisting and/or cueing Resident 47 with his meal. During the observation of the breakfast meal, conducted on 9/13/2022 at 9:15 A.M., Resident 36 was not observed in the dining room. Resident 36 was in her room, seated in her wheelchair. The door to Resident 36's room was closed and there were no staff noted in her room. The resident was observed with her breakfast meal on an overbed tray table in front of her. She had a bath towel draped over her right shoulder. She was observed to be attempting to feed herself the pureed food. She had smeared a large portion of her food all over her clothing, the tray table and her beverage cups and her hands. She pointed at a plastic coffee cup, which was upside down, and stated "I can't get that open." LPN 13 was summoned from the hallway and queried as to why Resident 36 was eating in her room behind a closed door without any assistance. LPN 13 indicated the dining room was sometimes too much stimulation for Resident 36 and indicated Resident 36 "does well" with utensils and feeding herself. LPN 13 made no comment when informed the resident had been observed on multiple meals feeding herself pureed food with her fingers. Resident 36 was observed attempting to drink from her empty beverage cups and LPN 13 indicated she would bring her another drink. At 9:20 A.M., LPN 13 and another nursing staff member were observed removing the breakfast			

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	tray from Resident 36's room, wiping down the overbed table and told the resident "You are all done [resident's name]." There was no additional beverage provided to Resident 36 and she was not assisted to finish the rest of the food left on her plate. During an interview with the MDS (Minimum Data Set) Coordinator, conducted on 9/14/2022 between 10:20 A.M. - 10::45 A.M. she indicated she would expect staff to attempt to assist them by offering a resident observed feeding themselves inappropriate food items with their fingers, silverware or feeding assistance. The clinical records for the following residents were reviewed on 9/14/2022 with the MDS coordinator: Resident 27's most recent quarterly MDS assessment, completed on 7/6/2022 indicated the resident required the extensive staff assistance of one staff for eating needs. The MDS coordinator indicated Resident 27 would sometimes feed herself without issues, but other times required cues. She indicated at the time; Resident 27 would refuse staff assistance to eat. Resident 34's most recent MDS assessment, completed on 7/29/2022 indicated the resident required extensive staff assistance of one for eating needs. The MDS coordinator indicated the resident would not always allow staff assistance and would sometimes use her utensils and other times just fed herself with her fingers. Resident 35's most recent MDS assessment, completed on 8/9/2022 indicated he required extensive assist with set up. The MDS coordinator indicated the resident needs lots of encouragement to feed himself and had very poor			

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	vision. Resident 47's most recent MDS assessment, completed on 8/24/2022 indicated the resident required extensive staff assistance for meal set up. The MDS coordinator indicated the resident would feed himself at times but usually required staff assistance to eat to finish his meal and he just would forget what he was to be doing. Resident 36 required the extensive assistance of one staff for eating needs. The MDS coordinator indicated it was "Hit or Miss" as to whether she would allow staff to assist her to eat. She indicated the resident would sometimes not allow staff assistance to eat. Resident 37 required extensive assistance of one staff for eating needs. The MDS coordinator indicated the resident was unable to feed himself and required total staff assistance for feeding needsDuring a random observation, on 9/08/2022 at 11:31 A.M., Resident 34 had long soiled fingernails. During an observation of Resident 34, on 9/12/2022 at 9:48 A.M., the resident's fingernails were dirty and her clothes visibly soiled with dry food. A clinical record review was completed on 9/13/2022 at 9:54 A.M. Resident 34's diagnoses included, but were not limited to: Alzheimer's disease, dementia, osteoporosis, and weakness. A Quarterly MDS (Minimum Data Set) Assessment, dated 7/29/2022, indicated Resident 34 required extensive assist of one staff with personal hygiene and total assistance with bathing.			

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	A current care plan, with a revised date of 8/25/2022, indicated the resident required assistance with ADL's (Activities of Daily Living) to maintain current functional status. Interventions included, but were not limited to: assist with bathing as needed, per resident preference, offer showers 2 times per week with partial bed baths in between, and assist with dressing, grooming, and hygiene as needed. During an observation on, 9/13/2022 at 10:36 A.M., Resident 34 continued to have a black substance underneath all of her fingernails. A shower schedule for the facility indicated Resident 34 was to have her showers on Sunday and Wednesday evenings. The CNA shower documentation indicated Resident 34 received a shower on Friday 9/9/2022 and Sunday 9/11/2022. During an observation, on 9/14/2022 at 10:27 A.M., Resident 34 was observed in the activity lounge sitting in her wheelchair with her fingernails visibly soiled with a black substance. During an interview, on 9/14/2022 at 10:49 A.M., CNA 4 indicated, "When you give a resident a shower you need to make sure to provide them privacy, wash hair and body, clean fingernails, shave if needed, and offer to brush teeth." During a continuous observation, on 9/13/2022 from 12:12 P.M. to 1:30 P.M., Resident 34 was seated away from the dining table. No staff were observed encouraging or assisting her to eat her lunch.			

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	Various nursing staff (Nurses, QMAs and Aides) were observed to walk past the resident in and out of the dining room with no assistance or encouragement given. Resident 34's meal consisted of chicken, green beans, rice and peaches. She had only consumed the peaches, mighty shake, and milk. The chicken, green beans and rice had not been touched. During an interview on, 9/13/2022 at 1:31 P.M., the MDS Coordinator indicated she had been assisting another resident to eat and did not know Resident 34 had not eaten. She indicated the staff should have tried to encourage and/or assist her to eat. On 9/14/2022 at 1:46 P.M,. the Regional Director of Clinical Services indicated, the facility did not have a specific policy regarding showers. 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review and interview, the facility failed to provide activities for 1 of 1 residents that were reviewed for	F 0679	**What corrective action(s) will be accomplished for those residents found to have been**	10/07/2022

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	transmission based precautions. (Resident 41) Finding includes: During an observation, on 9/9/2022 at 10:30 A.M., Resident 41, who was currently in transmission based precautions, was observed lying in her bed. The television was off, the room was quiet, lighting was dim, blinds were closed and the privacy curtain was pulled. During an observation, on 9/12/2022 at 9:29 A.M., Resident 41 was observed lying in bed, the television was off. A clinical record review was completed on 9/12/2022 at 11:15 A.M. Resident 41's diagnoses included, but were not limited to: Non- traumatic brain dysfunction, dementia, anxiety, depression, psychosis, hearing loss and pancreatic cancer. An Annual MDS (Minimum Data Set) assessment, dated 2/23/2022, indicated Resident 41 had a BIMS (Brief Interview for Mental Status) score that indicated severe cognitive impairment. The activities section for preferences, indicated it was very important to have :books; magazines; newspapers; listening to music; being around animals; attending group activities; going outside for fresh air and participating in religious activities. The MDS indicated Resident 41 required extensive assist of 1 staff for bed mobility, transfers, dressing and toileting, and required limited assist for eating. A current careplan, dated 4/2/2021, indicated Resident 41 enjoyed the following activities: reading, books, newspapers, listening to music,		**affected by the deficient practice;** Facility reviewed all residents in transmission based precautions to ensure that residents have supplies that will meet interest of need for activities. **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;** All residents in transmission based precautions have the potential to be affected by the deficient practice. Activities director/designee will audit activity preferences for any resident that enters transmission based precautions and ensures they activities can meet the preference of the resident while in transmission based precautions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Activity director/designee will inservice the activity department on providing activities or items which the resident prefers to meet the interests of and support the physical, mental, and psychosocial well being of each resident in transmission based precautions.	

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ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

(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
	being around animals, being outside when the weather is nice and religious activities. Interventions included but were not limited to: provide independent supplies for room and provide assistance with activities as needed. During an interview, on 9/12/2022 at 3:01 P.M., the Social Service Director indicated Resident 41 had a lot of visitors, but will locate records as it relates to the resident. During an observation, on 9/13/2022 at 9:13 A.M., Resident 41 was observed lying at the foot of her bed, with the television on but the screen was blank. The resident was unable to visualize the television due to it being positioned behind her head. During an observation, on 9/13/2022 at 1:32 P.M., Resident 41 was observed lying at the foot of her bed , television was on with a blank screen and unable to visualize the television screen. On 9/13/2022 at 1:40 P.M., the Social Services Director provided a report for activities, dated 9/1/2022-9/11/2022, which indicated Resident 41 had only participated in family visitation. On 9/14/2022 at 2:23 P.M., the Executive Director provided a policy titled, "Activities", dated 1/2006, and indicated the policy was the one currently being used by the facility. The policy indicated ..." It is the policy of this facility to provide for an ongoing program of captivities designed to meet the interest and the physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment...." 3.1-33(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Activity director/designee will complete the activities in transmission based precautions QAPI tool weekly for 4 weeks, monthly for 6 months If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies will be corrected 10/7/22	

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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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure foods were labeled and dated, and failed to remove expired foods. In addition, the facility failed to follow the recipe when preparing pureed foods, and failed to ensure cookware were clean and stored appropriately in 1 of 1 kitchen reviewed. This deficient practices had the potential 53 of 53 resident who received meals prepared by the kitchen. Findings include: A tour of the kitchen was conducted on 9/08/2022, at 9:54 A.M., with Dietary Saff 5 the	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Dietary manager audited foods in dry storage, refrigerator, and freezer, and removed any expired foods or foods that were not labeled/dated. Dietary manager cleaned all kitchen drawers to ensure no crumbs/food residue was in them. Cook's educated on following the recipes when preparing pureed foods and also	10/07/2022

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	following were observed during the tour: A container of sliced cheese with a use by date of 8/17/2022. A container of hard boiled eggs with a use by date of 9/7/2022. A undated tray of mighty shakes. A undated open bag of frozen peas. Two open bags of salami pieces and a bag of chicken patties that had expired. Inside the refrigerator on the bottom was a dried red substance. During an interview on 9/8/2022 at 10:00 A.M., the Administrator indicated the foods should be labeled and dated. During an observation on 9/9/2022 at 11:29 A.M., the Certified Dietary Manger (CDM) was preparing pureed foods. Four bratwurst had already been placed in the blender. The CDM indicted there were 7 pureed diets. She then poured water into the blender and pureed the meat. The CDM then added thickener to thicken up the pureed meat. The CDM was not observed to measure out the water or thickener prior to adding to the pureed meat. The CDM placed 30 ounces of sauerkraut into the blender. The CDM then added water into the blender and blended the vegetable. The CDM was not observed to measure the water prior to pureeing the sauerkraut. During an interview, on 9/9/2022 at 11:41 A.M., the CDM indicated what she put in was about 2/3's of a cup and she followed the recipes for the pureed the foods. On 9/9/2022 at 11:45 A.M., Dietary Staff 5 provided a recipe for pureed Braised Red Cabbage and indicated this is what they use for pureeing		educated on ensuring cookware is cleaned and stored appropriately. Maintenance director cleaned dust and dirt build up in the light covers, Maintenance also cleaned wall behind plate warmer and steamer of sticky substance. **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;** All residents who reside in the facility have the potential to be affected by the deficient practice. Dietary manager/designee to educate culinary staff on labeling/dating food and removal of expired foods, following standardized recipes, cleanliness and sanitation, and the cleaning and storage of cookware. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Dietary manager/designee to educate culinary staff on labeling/dating food and removal of expired foods, following standardized recipes, cleanliness and sanitation, and the cleaning and storage of cookware. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date**	

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	the sauerkraut. The policy indicated for 5 serving use 2/3's cup of food thickener was to be used. For 10 servings the policy indicated to use 1 1/3 cups of food thickener was to be used. During a follow up observation 9/9/2022 at 11:38 A.M., the following issues were observed: 9 light covers had dirt and dust built up. Cookware was observed with dried food particles and visible water. 2 kitchen drawers had visible food crumbs in them. The wall behind the plate warmer a had large accumulation of dried food and a red sticky substance. On 9/14/2022 at 11:20 A.M., the Administer provided the policy titled, "Food Storage", dated 10/2017, and indicated the policy was the one currently used by the facilty. The policy indicated "...4. All container must be accurately labeled and dated...12. Leftover prepared foods prepared are to be stored in covered . containers or wrapped securely. The food must clearly be labeled with the name of the product, the date it was prepared and marked to indicate the date by which the food shall be consumed or discarded. 13 Refrigerated, ready-to-eat, potentially hazardous food purchased from approved vendors, shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. Label these items when opened and use or dispose of within 30 days of opening to ensure quality. 14...e. All foods should be covered or wrapped tightly, labeled and dated. 15...d. Foods should be covered or wrapped tightly, labeled and dated with an open date on it...." On 9/14/2022 at 11:21 A.M., the Administer		**the systemic changes for each deficiency will be completed;** Dietary manager/designee will complete QAPI tools for food labeling/dating, following standardized recipes, and the cleaning and storage of cookware weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 10/7/22	

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	provided the policy titled, "Standardized Recipe", dated 10/17, and indicated the policy was the one currently used by the facility. The policy indicated, "... to train the cooking staff to correctly follow menus by following the recipes set forth and completing production as outlined on production guides...". On 9/14/2022 at 11:21 A.M., the Administer provided the policy titled, "General Food Preparation and Handling", dated 02/02, and indicated the policy was the one currently used by the facility. The policy indicated, "...1. The kitchen is clean, neat and orderly and equipment is kept clean...13 Handle utensils, cups, glasses and dishes in such a way as to avoid touching surfaces with which food or drink will come into contact...." On 9/14/2022 At 11:21 A.M., the Administer provided the policy titled, "Cleaning Dishes and Dish Machine", dated 10/17, and indicated the policy was the one currently used by the facility. The policy indicated "...7. Air-dry all items...." 3.1-21(3)			
F 0920 SS=E Bldg. 00	483.90(h)(1)-(4) Requirements for Dining and Activity Rooms §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and			

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	§483.90(h)(4) Have sufficient space to accommodate all activities. Based on observation and interviews, the facility failed to ensure there was sufficient space in the dining room. This potentially affected 30 of 53 residents in the building that ate their meals in the dining room. Findings include: During an observation of the noon meal, conducted on 9/8/2022 at 12:00 P.M. - 1:10 P.M., the following was noted: There were three square shaped tables located along the west side of the main dining room. Residents were seated in either dining room chairs and/or wheelchairs, three residents to a table, one side of the table was against the wall. The residents seated on the sides of the table in between each table could not scoot their chair and/or wheelchair back to exit the table without having the resident directly behind them seated at the adjacent table moved. In addition, there were two tables positioned on either side of the to the kitchen door where staff obtained meal trays, beverage carts and supplies from the kitchen. The resident seated with his/her back to the open kitchen door was constantly being brushed up against by some of the staff going behind him to obtain food trays and supplies. Resident 37 was seated at a table close to the kitchen door and needed total staff assistance for feeding. There was another table located directly behind his table and the kitchen door was located on the other side of his table. Staff were noted to have to squeeze by other residents, eating at those tables, to get to a chair placed beside Resident 37 to assist him. Staff were noted to either move the other residents briefly and/or place their uniforms	F 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** IDT team moved tables from the main dining room to the second dining room in the facility and opened it up for service to open up more space in the main dining room, residents and staff now have ample amount of space to move individually in or out of the dining room without disrupting any other resident meal service. Educated staff on ensuring residents in reclining chairs have their chairs repositioned to ensure that their legs can fit safely under the table for meal service. **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;** 30 of 53 residents eating in the dining room have the potential to be affected by the deficient practice. IDT team moved tables from the main dining room to the second dining room in the facility and opened it up for service to open up more space in the main dining room, residents and staff now have ample amount of space to move individually in or out of the dining room without disrupting any other resident meal service.	10/07/2022

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	and bodies against the tables to get in and out. Two residents in large, reclining chairs, were unable to fit underneath the facility dining tables and had to be placed sideways along the table while they were assisted to eat. During the meal observation, Resident 42 was heard requesting assistance to leave the dining room. Staff had to move another resident at an adjacent table for her to exit the dining room. During an observation of the noon meal, conducted on 9/13/2022 at 12:20 P.M., Resident 28 was noted to be seated in a dining room chair place sideways along the dining table. Resident 38 was noted to be seated at an adjacent table in a wheelchair directly behind Resident 28. Resident 38 was noted to have finished her meal and stacked her dishes. During an interview with Resident 38 she indicated she could not leave until her roommate, Resident 28 moved. She was then heard asking Resident 28 how long they were going to be at the tables. There was not enough space in between the resident's chairs, even with Resident 28 seated sideways to allow Resident 38 to leave the dining without having Resident 28 move first. During an interview with the Administrator, regarding dining spacing on 9/14/2022 at 1:48 P.M. he indicated in the past the facility had split the resident's 1/2 and 1/2 between the dining room and an assisted dining/activity room but had recently brought them back together in the same dining room. He was unaware of the issues with residents not being able to get in and out without moving other residents. He indicated the building did have space constraints but thought he could fix the issue by rearranging the tables		Educated staff on ensuring residents in reclining chairs have their chairs repositioned to ensure that their legs can fit safely under the table for meal service. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** ED/designee to in-service staff on **utilizing both dining areas,** ensuring all residents have proper space and able to move freely in and out of the dining room without disrupting other residents meal service, and that residents in reclining chairs have been repositioned to ensure that their legs can fit safely and comfortably under the table for meal service. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** ED/designee to complete QAPI tool ensuring proper spacing in the dining room weekly for 4 weeks, monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the QAPI Committee for review and follow up. Deficiencies corrected by 10/7/22	

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	and their configuration. During an interview with the Administrator, conducted on 9/14/2022 at 2:22 P.M., he indicated the facility did not have a specific policy regarding space in the dining room. 3.1-19(cc)			