STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056167	A. BUILDING _____ B. WING _____	10/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTINELA SKILLED NURSING & WELLNESS CENTRE WEST	950 FLOWER STREET INGLEWOOD, CA 90301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Recertification Survey conducted on 10/10/2023 to 10/13/2023. Representing the Department of Public Health: Surveyor #46832, Health Facilities Evaluator Nurse Surveyor #47932, Health Facilities Evaluator Nurse Surveyor #47978, Health Facilities Evaluator Nurse Surveyor #40994, Pharmacy Consultant Surveyor #38740, Dietary Consultant Facility Census: 52 Resident Sample Size: 13 Highest Scope and Severity: E	F 000	**Preparation, submission 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 this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law.**	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must– (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582	**F582** **Corrective action for residents found to have been affected by this deficiency:** Upon identification on 10/12/2023, Business Office Manager reviewed all resident from April 1,2023 to present who has a Notice of Medicare Non – Coverage and Advance Beneficiary Notice of Non coverage.	10/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/02/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	F 582	**Corrective action for residents that maybe affected by this deficiency:** Business Office Manager reviewed the Notice of Medicare Non-Coverage and Advance Beneficiary Notice of Non coverages for completion and accuracy from April 1, 2023, to October 12, 2023. No other resident was affected by the same deficient practice. **Measures that will be put into place to ensure that this deficiency does not recur:** BOM will review all Resident with Notice of Medicare Non-Coverage and Advance Beneficiary Notice of Non-Coverages during daily clinical meetings. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Business Office Manager will conduct an audit of Resident with Notice of Medicare Non-Coverage and advance Beneficiary Notice of Non-Coverage for completion and	10/13/23

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F 582	Continued From page 2 facility failed to ensure the Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage form (SNFABN, a document issued by medical providers to Medicare recipients, warning that services might not be covered; formally and legally transfers liability for payment of services to the Medicare recipient instead of Medicare) was completely filled out, by having one of three residents (Residents 256), chose one of the options for billing the anticipated non-covered inpatient skilled nursing facility (an in-patient rehabilitation and medical treatment center staffed with trained medical professionals) stay. This deficient practice had the potential to affect the skilled nursing services needed to progress and achieve the highest practicable physical, mental, and psychosocial wellbeing of the affected resident (Resident 256). Findings: During a review of the admission record indicated Resident 256 was originally admitted to the facility on 3/13/2016 and an initial admission date of 2/26/2023 with diagnoses that included, but not limited to hypertensive heart disease (a heart condition caused by high blood pressure), heart failure (a chronic condition where the heart does not pump blood as well as it should), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). During a review of Resident 256's SNF Advance Beneficiary Notice of Non-coverage (SNFABN, a document issued by medical providers to	F 582	accuracy. Any negative trends and patterns will be reported in the monthly QAA committee meeting for further review and recommendation for 3 months, then quarterly thereafter.	

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F 582	Continued From page 3 Medicare recipients, warning that services might not be covered; formally and legally transfers liability for payment of services to the Medicare recipient instead of Medicare) form signed on 3/31/23, the SNFABN form indicated Resident 256's inpatient skilled nursing facility (an in-patient rehabilitation and medical treatment center staffed with trained medical professionals) stay will not be covered effective 4/4/2023. The Reason Medicare may not pay was due to SNF benefits have exhausted. The three options sections (for billing the anticipated non-covered inpatient skilled nursing facility stay) for Resident 256 were left blank. During a review of the undated document titled, Notice of Medicare Provider Non-Coverage document for Resident 256, indicated the effective date of current skilled nursing services will end on 4/3/2023. It also indicated Resident 256's financial liability will begin on 4/4/2023. During a concurrent interview and record review with the Business Office Manager (BOM), on 10/11/23 at 4:02 p.m., the BOM stated the protocol for beneficiary notices are, all beneficiary forms must be given to the residents 72 hours before their coverage ends. The BOM stated the facility's business office was responsible for providing all residents or the residents' responsible party with the form, explaining the options to the residents and/or responsible party and have residents and/or responsible party choose 1 of 3 options listed on the form. The BOM stated one option on Resident 256's beneficiary form should have been checked but was missed.	F 582		

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F 582	Continued From page 4 During an interview with the administrator (ADM), on 10/12/23 at 2:26 p.m., the ADM stated Notice of Medicare Non-Coverage and Advance Beneficiary Notice of Non-Coverage should be explained to residents and they should be informed of the financial liability for the services provided.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) assessment, a comprehensive assessment and care planning tool, regarding the pneumococcal vaccination (vaccine to prevent pneumococcal disease), was conducted for one of two sampled residents (Resident 3). This deficient practice had the potential for a poor care planning which can affect the health and safety of the affected resident (Resident 3). Findings: During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was originally admitted to the facility on 11/3/2021 and was readmitted on 4/22/2022 with diagnosis that included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dysphagia (difficulty of swallowing), aphasia (loss of ability to understand or express speech, caused by brain	F 641	**F641** **Corrective action for residents found to have been affected by this deficiency:** 1) Upon Identification, Resident 3 MDS Assessment was reviewed, modified and completed on 10/13/23. 2) Resident 3 was offered for Pneumococcal Vaccination on 10/24/23. **Corrective action for residents that maybe affected by this deficiency:** 1) On 10/24/- 10/30/23 the Director of Nursing Services and RN Supervisor checked and audited the current Resident's admission assessment for completeness and accuracy with emphasis on Pneumococcal Vaccination. No other Resident were affected by this deficient practice.	10/13/23 10/24/23 10/24/23 10/30/2023

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F 641	Continued From page 5 damage) and dementia (the loss of thinking, remembering, and reasoning). During a review of Resident 3's Minimum Data Set (MDS), a comprehensive assessment and care planning tool) dated 8/10/2023, the MDS indicated Resident 3's cognitive skills for daily decision making was severely impaired. The MDS, indicated Resident 3 required extensive assistance from staff with one-person physical assist in bed mobility, transfer, dressing, personal hygiene, and bathing. The MDS also indicated, Resident 3's Pneumococcal Vaccine (vaccine to prevent pneumococcal disease) was coded as 1 (up to date). During a review of Resident 3's Pneumococcal Vaccination, the Consent or Refusal (PVCR) form dated 11/8/2021 indicated Resident 3's responsible party refused for Resident 3 to receive the Pneumococcal Vaccine. During an interview on 10/13/2023 at 8:55 a.m. with the MDS nurse (a nurse that collects and assess information for the health and well-being of residents in Medicare or Medicaid certified nursing homes), the MDS nurse stated the MDS are completed upon admission, quarterly and yearly. The MDS nurse also stated if there was a significant change of resident's status, the facility should transmit a new MDS. When asked if the MDS assessment dated 8/10/2023 under section 00300 Pneumococcal vaccine was completed accurately, the MDS nurse stated it was a wrong assessment. It should have been coded 2 (as offered and declined), not 1, since Resident 3 refused to receive the Pneumococcal Vaccine. The MDS nurse stated if the facility did not put	F 641	2) All Resident vaccination record were audited. No other resident affected by deficient practice. **Measures that will be put into place to ensure that this deficiency does not recur:** 1) In-service education was provided by the Director of Nursing on 10/25/23- 10/31/23 to Licensed Nurses regarding assessment accuracy emphasizing in developing, reviewing, revising/updating resident's Vaccination Record are reflected and coded on their respective assessment. 2) IP Nurse will monitor timely completion of Vaccination Records signs during monthly audits. Medical Records will audit completion as scheduled. 3) In-Service provided by MDS Consultant to MDS Nurse on 10/31/2023 regarding MDS Accuracy with emphasis on Section 00300 A & B. **Measures that will be implemented to monitor the continued effectiveness of the**	10/31/2023 10/31/2023

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F 641	Continued From page 6 the correct assessment in the MDS, there would be a problem in billing and with the care of the resident. During a review of the facility's policy and procedure (P&P), titled "RAI process", revised October 4, 2016, indicated "the facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS RAI MDS 3.0 Manual".	F 641	**corrective action taken to ensure that this deficiency has been corrected and will not recur:** Assessment of inaccurate trends or concerns will be communicated by Director of Nursing to the QA & A committee for further evaluation and recommendations. If it is determined that we have accomplished the objectives in the POC above the results are successful, then the facility will consider the matter resolved. The QA & A committee will continue to review until such time that the deficiency has been proven to be resolved for 2 consecutive quarters and advised by and/or advised by the QA & A Committee.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow its policy and procedure by ensuring one of one sampled resident (Resident 42), had a titration order (order to adjust flow of oxygen to achieve target oxygen level range in the system) for oxygen use, and ensuring the oxygen tubing was changed and labeled every seven days per policy. The deficient practice had the potential to cause respiratory complications and had the potential	F 695	**F695** **Corrective action for residents found to have been affected by this deficiency:** 1) Upon identification on 10/12/2023 Resident 42 oxygen tubing was dated and labeled. 2) Upon identification on 10/12/2023 Oxygen order for Resident 42 was notified and clarified to MD.	10/12/23 10/12/23

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F 695	Continued From page 7 for facility acquired respiratory infections associated with oxygen therapy. . Findings: During an observation on 10/10/2023 at 10:10 a.m., Resident 42 was receiving oxygen at two (2) liters per minute (LPM) via nasal cannula (a small flexible tube that has two open prongs that sit inside the nostrils used to deliver oxygen). The oxygen regulator (regulator that controls the flow of oxygen) was set at 2 LPM. During an observation on 10/12/2023 at 7:57 a.m. at Resident 42's room, Resident 42 was receiving oxygen at three (3) LPM via nasal cannula. Resident 42's oxygen tubing had no label and date. During an interview on 10/12/2023 at 8:10 a.m. with the Director of Nursing (DON), the DON confirmed that Resident 42's oxygen tubing was not dated and labeled. The DON stated our practice is to put the date on the plastic bag and on the oxygen tubing. The DON can't verify when the oxygen tubing was last changed because it was not labeled and dated. During an interview on 10/12/2023 at 9:40 a.m. with the Licensed Vocational Nurse 1 (LVN) and DON, LVN 1 stated Resident 42's physician orders for oxygen was 2-3 liters per minute as needed for shortness of breath. LVN 1 stated Resident 42 sometimes increased his oxygen flow to 4 liters per minute by herself. The DON stated that Resident 42's physician's order for oxygen was not clear and was confusing for the nursing staff. The DON stated the physician	F 695	**Corrective action for residents that maybe affected by this deficiency:** Residents receiving Oxygen Therapy were checked and reviewed by the Director of Nursing on 10/25/23. No other Resident were affected. **Measures that will be put into place to ensure that this deficiency does not recur:** 1) RN Supervisor will review and check all residents with Oxygen order on a weekly basis to ensure all tubing is dated and labeled. 2) In Service provided by Director of Nursing on 10/12/23-10/18/23 to all Licensed Nurse about the Facility's Policy and Procedure on Oxygen Therapy with emphasis on dating, label and changing Oxygen tubing on a weekly basis as well as oxygen orders will have parameters specified by the physician. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure**	10/25/23 10/12/23 to 10/18/23 10/25/23

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F 695	Continued From page 8 order should have included titration order and parameters. The DON stated I will have LVN 1 call the doctor and clarify the oxygen order of Resident 42. During a review of Resident 42's Admission Record, the Admission Record indicated Resident 42 was admitted to the facility on 7/8/2023 with diagnoses of chronic obstructive pulmonary disease (a lung disease characterized by long term poor airflow), encephalopathy (damage or disease that affects the brain), and congestive heart failure (a chronic condition in which the heart doesn't pump blood as well it should). During a review of Resident 42's History and Physical (H&P), dated 8/7/2023, the H&P, indicated Resident 42 has the capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS), a standardized assessment and care screening tool, dated 7/14/2023, the MDS indicated Resident 42 required extensive assistance in dressing, toilet use, and personal hygiene. The MDS indicated Resident 42 was on oxygen therapy. During a review of Resident 42's Physician Order dated 7/8/2023, the physician order indicated, "May use oxygen at 2-3 liters per minute via nasal cannula for shortness of breath as needed and to change the oxygen tubing weekly on Sunday and as needed." During a review of the facility's policy and procedure (P&P) titled, "Oxygen Therapy",	F 695	**that this deficiency has been corrected and will not recur:** Findings from weekly review by RN Supervisor will be presented by Director of Nursing during QA Committee meeting monthly for further recommendations & resolution. If it is determined that we have accomplished the objectives in the POC above and the results are successful, then the facility will be considered the matter resolved. The QA & A committee will continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA & A committee.	

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F 695	Continued From page 9 revised November 2017, the P&P indicated, "oxygen titration orders will have parameters specified by the physician (example: 02 @ 2-4 L/min to maintain 02 @ saturations at or above 92%) and the humidifier and tubing should be changed no more than every 7 days and labeled with the date of change.	F 695	**F761** **Corrective action for residents found to have been affected by this deficiency:**	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 761	Upon Identification on 10/11/2023 unopened insulin lispro and unopened insulin aspart was removed from Medication Cart and discarded. **Corrective action for residents that maybe affected by this deficiency:** All Insulin in Medication Cart were reviewed and checked for Unopened Insulin by Director of Nursing. No other unopened insulin stored at room temperature was identified. **Measures that will be put into place to ensure that this deficiency does not recur:** 1) RN Supervisor will log and review All Resident with Insulin order on a weekly basis to identify Insulin are stored according to the Manufacturer's requirements.	10/11/2023 10/30/2023

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F 761	Continued From page 10 review, the facility failed to ensure two insulin pens (a type of medication used to treat high blood sugar) requiring refrigeration were stored according to the manufacturer's requirements affecting Residents 10 and 21, in one of two inspected medication carts (West Back Medication Cart 1.) The deficient practices of failing to store medications per the manufacturers' requirements increased the risk that Residents 10 and 21 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization. Findings: During a concurrent observation and interview on 10/11/2023 at 2:10 p.m. of the West Back Medication Cart 1 with the Licensed Vocational Nurse 1 (LVN), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date, as required by their respective manufacturer's specifications: 1. One unopened insulin lispro (a type of insulin used to treat high blood sugar) pen for Resident 21 was found stored at room temperature. According to the manufacturer's product labeling, unopened insulin lispro pens must be stored in the refrigerator. 2. One unopened insulin aspart (a type of insulin used to treat high blood sugar) pen for Resident 10 was found stored at room temperature. According to the manufacturer's product labeling, unopened insulin aspart pens should be stored in the refrigerator.	F 761	2) In Service provided to Licensed Nurses by the Director of Nursing on 10/25/2023 regarding Medication Storage with emphasis on Unopened Insulin should be securely and properly stored per manufacturers recommendations. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Director of Nursing will be responsible for tracking or monitoring all medication, especially Insulin is stored according to the manufacturer's requirement. Findings will be communicated to the QA & A Committee monthly for further evaluation and recommendations. If it is determined that we have accomplished the objectives in the POC above and the results are successful, then the facility will be considered the matter resolved. The QA & A committee will continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA & A committee.	10/31/2023

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F 761	Continued From page 11 LVN 1 stated the insulin for Residents 10 and 21 were not stored properly according to the manufacturer's requirements. LVN 1 stated when an insulin is unopened, it must remain in the refrigerator. LVN 1 stated she does not know why the insulin for Residents 10 and 21 are stored in the medication cart. LVN 1 stated if the insulin is stored at room temperature, the expiration date is shortened significantly and needs to be discarded much sooner. LVN 1 stated when insulin is stored improperly at room temperature, there is a risk of administering it to the resident once it has expired. LVN 1 stated administering expired insulin to residents could result in poor blood sugar control which could cause medical complications possibly leading to hospitalization. A review of the facility's policy titled, "Medication Storage in the Facility," dated 2/23/15, indicated "Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations ... medications requiring 'refrigeration' ... are kept in a refrigerator with a thermometer to allow temperature monitoring ... "	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804	**F804** **Corrective action for residents found to have been affected by this deficiency:** 1) Upon identification of the deficient practice on 10/10/2023, All Cooks were In Service on how to prepare puree recipes and how to achieve target consistencies without the loss of flavor.	10/10/23

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F 804	Continued From page 12 by: Based on observation, interview and record review, the facility failed to prepare food by methods that conserved flavor, texture, and appearance for one of one puree food test-tray. The texture of the pureed diet was sticky and gummy with glossy and shiny appearance. When tasted the food was sticky to palate and gums and difficult to swallow and the flavor was bland. This deficient practice had the potential to result in meal dissatisfaction, decreased intake and placed Four resident on the puree diet at risk for unplanned weight loss. Findings: During initial facility tour on 10/10/2023 at 9:00 a.m., complaints about the temperature and flavor of the food were identified. During an observation and interview in the kitchen on 10/10/2023 at 10:00 a.m., Cook1 was preparing the lunch menu. Cook1 said the lunch includes chicken, creamy pasta, and spinach. Cook1 was cooking the chicken in the oven, she had prepared the creamy sauce for the pasta and was steaming the spinach on the stove. Cook1 stated, once food is cooked will take a portion and will blend for the residents on the pureed diet. Cook1 said that she blends with the juices of the chicken or adds broth then adds thickener until the consistency is thick and is not runny. During an observation of the tray line service for lunch at 11:45 a.m., the pureed spinach was thick and had sticky consistency, it was sticking to the serving scoop. The pureed spinach looked shiny and glossy.	F 804	2) On 10/26/2023, Cook 1 was given a one on one In Service by Dietary Supervisor on how to prepare puree recipes and how to achieve target consistencies without the loss of flavor. **Corrective action for residents that maybe affected by this deficiency:** All residents on puree diet were reviewed. No other residents were affected by this deficient practice. **Measures that will be put into place to ensure that this deficiency does not recur:** 1) On 10/10/23, Dietary Supervisor and Regional Dietician conducted an in-service to all cooks on how to Prepare puree recipes and how to achieve target consistencies without the loss of Flavor. 2. Dietary Supervisor will complete test tray audits on a weekly basis to observe texture and flavor of puree food items. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure**	10/26/23 10/10/23

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F 804	Continued From page 13 During the test tray on 10/10/2023 at 12:34 p.m., the pureed spinach was thick, clinging or sticking to the mouth and palate and difficult to clear the mouth and swallow like a peanut butter consistency. The taste was bland and didn't taste that it had cheese per recipe. The pureed pasta was bland and had no creamy pasta taste like the regular unblended pasta. During a concurrent interview with the Dieatry Supervisor (DS) and Registered Dietitian (RD1), the DS said the pureed food could use a little more seasoning. RD1 stated the puree should have an apple sauce like consistency and not thick like this spinach. RD1 agreed that the balance of the thickness is off in the spinach and will discuss with the cooks. During an interview with Cook1 on 10/10/34 at 1:30 p.m., Cook1 said she adds a portion of the cooked food in the blender and sometimes adds broth. Once blended, she adds enough thickener that will make the consistency thick and not runny. Cook1 said she does not measure how much thickener she uses. A review of facility menu titled "recipe: pureed vegetables" indicated, "complete regular recipe, measure out the total number of potions needed for puree diets, puree on low speed, puree should reach the consistency of applesauce."	F 804	**that this deficiency has been corrected and will not recur:** Dietary Supervisor will conduct monthly skilled competency test to cooks on proper food preparation. Any negative trends and concerns will be reported to the monthly QA committee meeting by the Dietary Supervisor further resolution. If it is determined that we have accomplished the objectives in the POC above and the results are successful, then the facility will be considering the matter resolved. The QA & A committee will continue to review until such time that the deficiency has been proven to be resolved for 3 consecutive months and/or advised by the QA & A committee. **F812** **Corrective action for residents found to have been affected by this deficiency:**	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812	1) Upon identification on 10/10/23, three bags of hash browns and apple sauce were discarded immediately by Dietary Supervisor.	10/10/23

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F 812	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen were followed when: 1. Three bags of breaded potato hash browns were stored in the reach-in freezer with no date label. One large container of apple sauce was store in the reach-in refrigerator with no date. 2. Personal water bottles were stored in the facility two door reach-in refrigerator. 3. Nutritional supplement labeled "store frozen", with manufactures instruction to use within 14 days of thawing, were not monitored for the date they were thawed to ensure expired shakes were discarded after this time frame. 30 strawberry flavored nutrition supplements were stored in the reach in refrigerator with no thaw date. This	F 812	2) Personal water bottles were removed and discarded immediately by Dietary Supervisor on 10/10/2023. 3) Upon identification of Nutritional Supplement with no date were removed and discarded immediately on 10/10/23 by Dietary Supervisor. 4) Juice Machine tubing connectors and coffee machine was washed with mild soap and water, sanitized and wiped with soft cloth by Dietary Aide 1. on 10/10/2023. 5) Upon identification, Unopened milk, Arizona Tea and leftover beans were removed and discarded by Licensed Nurse on 10/10/2023. **Corrective action for residents that maybe affected by this deficiency:** On 10/11/2023, Dietary Supervisor checked the refrigerators, freezer and food storage for any expired, unlabeled and personal food or drinks and none was found. **Measures that will be put into place to ensure that this deficiency does not recur:**	10/10/23 10/10/23 10/10/23 10/10/23 10/11/23

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F 812	Continued From page 15 deficient practice had the potential to result in food borne illness (food poisoning caused by consuming contaminated food, beverages, or water) in 9 residents who are on nutrition supplements at the facility. 4. Juice machine tubing connectors were sticky and had drops of dried sticky residue, two gnats were flying around the sticky tubing connectors. One juice tubing connector was not attached to juice box and was hanging close to the floor and touching other juice boxes. Coffee making machine glass gauge pipe was stained with dark brown color residue. 5. Resident food brought from outside, including leftovers, were stored in the resident refrigerator with no label and date. Resident (1) had three containers of leftover cooked beans stored in the refrigerator with no date. This deficient practice had the potential to result in food borne illness in one resident who had food stored in the resident refrigerator with no date. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 49 out of 52 residents who received food from the kitchen and Resident 1 who stored and consumed personal foods from the resident refrigerator. Findings: 1. During an observation in the kitchen on 10/10/2023 at 9:00 a.m., there were three large bags of breaded triangle shaped food items	F 812	1) Dietary Supervisor conducted an in-service on 10/11/2023 on labeling, proper thawing method and keeping personal items away from kitchen refrigerator. 2) Kitchen assistant will check the refrigerator, freezer, and food storage for expired items, labeling, and use by date weekly. 3) The Dietary Supervisor conducted an in-service on 10/26/2023 on proper cleaning of Coffee Machine and Juice Maker with emphasis on cleaning the tube connectors. 4) An in-service was provided by Director of Nursing to Licensed Nurses and CNA on 10/26/2023 regarding Food Brought from outside of the facility. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Dietary Supervisor will check food storage logs weekly to ensure all foods are not expired and properly labeled. Trends and concerns will be reported to the	10/11/23 10/26/23 10/31/23

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F 812	Continued From page 16 stored in the reach-in freezer with no label or date. During a concurrent interview with Dietary Aide (DA1), DA1 stated they are fish but was not sure and will have to check. During an observation in the kitchen on 10/10/23 at 9:10 a.m., there was a large container of apple sauce stored in the reach-in refrigerator with no date. During a concurrent interview with Dietary supervisor (DS), DS stated that everything in the refrigerator must be labeled and dated. DS said the apple sauce will be discarded since there is no date. A review of facility policy titled "Food Storage" policy No.DS-52 (revised7/25/2019) indicated, "All items will be correctly labeled and dated." A review of the 2022 U.S. Food and Drug Administration Food Code titled "Ready to Eat, Time/Temperature control for safety food, Date Marking" Code#3-501.17, indicated, "Ready to eat; time temperature control for safety food prepared and packaged by food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed, sold, or discarded." 2. During a concurrent observation and interview with DS on 10/10/23 at 9:15 a.m., there were 2 plastic water bottles stored in the kitchen refrigerator next to food preparation area. DS stated these belong to staff and staff should not	F 812	monthly QA steering committee meeting by the Dietary Supervisor for further recommendation and resolutions.	

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F 812	Continued From page 17 store their water bottles inside the refrigerators due to possible cross contamination with facility food for residents. 3. During an observation in the kitchen on 10/10/23 at 9:20 a.m.,there were 30 single serve cartons of strawberry nutrition supplement stored inside the dairy refrigerator with no date. During a concurrent interview with DS, DS stated the single serve carton of nutrition supplements are frozen and are stored in the refrigerator. DS said once thawed they are good for 14 days. DS agreed there should be a date on the supplements to monitor date of thaw. DS was not sure when the Strawberry flavored nutrition supplements were thawed. 4. During an observation in the kitchen on 10/10/23 at 9:30 a.m., juice machine tubing connectors were sticky to the touch, there were dark sticky spots on the tubing and there were two gnats flying around the sticky tubing and connectors. One of the tubing connectors was disconnected from the juice box and was hanging close to the floor and touching other juice boxes and tubing. During a concurrent observation and interview with the DS, the DS stated the juice machine in-serviced by the juice machine company. DS stated that kitchen staff are responsible to wipe down and clean the tubing and connectors. DS agreed that juice spills and dry sticky juices on tubing can attract pests such as gnats. During an observation in the kitchen on 10/10/23 at 9:40 a.m., observed the coffee maker machine had glass gauge pipe in front of the machine.	F 812		

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F 812	Continued From page 18 The pipes were half filled with coffee and there was dark brown stains inside the pipes. During a concurrent interview with DA1, DA1 stated that the pipes are cleaned every week with a special thin pipe brush. DA1 acknowledged that the glass pipe is dirty and said that it has not been cleaned. DA1 said that stained and dirty coffee maker can contaminate the coffee and change the quality. During an interview with DS on 10/11/23 at 1:30 p.m., DS stated that we will begin a new cleaning schedule log which will include the cleaning the juice box machine and connectors and the coffee machine. A review of facility policy titled "Bag-in Box juice Dispenser cleaning and sanitizing instructions" not dated indicated, "wipe down all connecting hoses and product rack, with a soft cloth and a mild soap and water solution." A review of facility daily cleaning schedule log indicated to clean the juice machine, nozzle, holder, and tray so no build up. Clean machine area no sticky counters. The cleaning schedule also includes to clean the coffee maker on daily basis. 5. During a review of Resident 1's Admission Record, the Admission record indicated Resident 1 was originally admitted to the facility on 9/24/1993 and was readmitted on 11/1/2016 with diagnoses of hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), affecting right and left dominant side, polyarthritis (joint pain and	F 812		

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F 812	Continued From page 19 stiffness) and right hand contracture (fixed tightening of muscle, tendons, ligaments, or skin). During a review of Resident 1's History and Physical (H&P), dated 5/1/2023, the H&P, indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care screening tool dated 7/25/2023, the MDS indicated Resident 1 required extensive assistance in bed mobility, transfer, toilet use, and personal hygiene. During an observation of Resident 1's food refrigerator in his room on 10/10/2023 at 1:25 p.m., it was observed one unopened carton of milk with used by date 10/18/2023, one unopened Arizona tea, and three containers of leftover cooked beans with no label and date. During an interview on 10/10/2023 at 1:35 p.m., with Certified Nursing Assistant 1 (CNA 1) at Resident 1's room, CNA 1 verified the three containers of left-over cooked beans with no label of date opened or when was it stored or kept in the refrigerator. CNA 1 stated she does not know who brought Resident 1's outside food. During an interview on 10/12/2023 at 8:45 a.m., with Director of Nursing (DON), the DON stated food brought from outside of the facility needs to be labeled and dated prior to keeping in Resident 1's food refrigerator. The DON stated it important to label and date outside food especially the perishable food because of the risk of food borne	F 812		

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F 812	Continued From page 20 illness. During a review of the facility's policy and procedure (P&P), titled "Food Brought in by Visitors", revised June 2018, the P&P indicated "When food is brought into a nursing home prepared by others, the nursing home is responsible for ensuring that the food container is clearly labeled with the resident's name and date received and stored in a refrigerator designated for this purpose".	F 812		