STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125045	A. BUILDING _____ B. WING _____	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALE ANUENUE RESTORATIVE CARE	1333 WAIANUENUE AVENUE HILO, HI 96720

(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 A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 11/28/2022 to 12/02/2022. The facility was not in substantial compliance with 42 CFR §483 Subpart B. Two facility-reported incidents (ACTS #HI9618 and #HI9531) were investigated and not substantiated. Two facility-reported incidents (ACTS #HI9528 and #HI9529) were investigated and substantiated. Survey dates: 11/28/2022 -12/02/2022 Census: 90 Sample size: 18	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		12/29/22

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

Electronically Signed | 12/28/2022

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure a urinary catheter drainage bag was covered to prevent it from being seen by other residents or visitors, to maintain dignity for 1 (Resident #19) of 2 sampled residents reviewed for urinary catheters. Findings included: Review of a facility policy titled, "Dignity," dated as reviewed 09/30/2022, revealed promoting resident independence and dignity included, "refraining from practices demeaning to residents, such as leaving urinary catheter bags uncovered."	F 550	1. A drainage bag cover was provided to Resident #19 on 12/1/22. Education was provided to nursing staff regarding use of drainage bag covers for indwelling catheters and changing as needed. 2. An audit of residents with indwelling catheters was done to determine if drainage bag covers were in place. Two other residents were identified. Both residents are ambulatory and utilize a drainage bag cover when they are out in a public area. 3. Drainage bag covers are provided to residents that utilize indwelling catheters. They are changed during routine care observations and replaced as needed. Education is provided to nursing staff	

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F 550	Continued From page 2 A review of an "Admission Record" revealed Resident #19 had diagnoses that included urinary retention and neurogenic bladder. A review of a quarterly Minimum Data Set (MDS), dated 10/31/2022, revealed the resident was in a persistent vegetative state. The MDS indicated Resident #19 was dependent on staff for all activities of daily living and had an indwelling urinary catheter. A review of a care plan, dated as revised 06/06/2022, revealed Resident #19 had a suprapubic catheter (a catheter that permits direct urinary drainage from the bladder through a surgical opening in the abdominal wall) inserted 04/16/2013. The care plan did not address the need to keep the urinary drainage bag covered. Observations on 11/28/2022 at 2:41 PM, 11/29/2022 at 4:00 PM, and 11/30/2022 at 10:00 AM revealed Resident #19 lying in bed. The resident's urinary catheter bag was hanging on the side of the bed facing the resident's roommate. There was no privacy cover on the drainage bag. During an interview on 11/30/2022 at 2:56 PM, Certified Nursing Assistant (CNA) #17 stated she had not seen the resident's catheter drainage bag covered and was unable to recall if she had been taught the drainage bag required covering. Observation on 12/01/2022 at 9:20 AM revealed Resident #19's urinary drainage bag remained uncovered. CNA #18 was interviewed on 12/01/2022 at 9:33 AM. The CNA stated she had not seen the urinary	F 550	regarding use of drainage bag covers for indwelling catheters and changing as needed. 4. The DON/designee will audit for presence of catheter drainage bag covers. If drainage bags covers are not being utilized, one will be placed and the Nurse and CNA will receive additional education. This will be done weekly for 30 days, then monthly for two months. The DON/designee will report the audit findings, along with any corrective action taken, to the QAPI Committee for review and recommendations. The QAPI Committee will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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F 550	Continued From page 3 drainage bag for Resident #19 covered with a privacy bag and indicated she had not been taught the drainage bag needed to be covered. The Social Services Assistant (SSA) was interviewed on 12/01/2022 at 10:46 AM. The SSA stated the ways to promote dignity for residents included covering urinary drainage bags when residents were out of their rooms. The SSA added that a privacy bag should be used when the resident was in their room as well, since visitors could enter a resident's room. Licensed Practical Nurse (LPN) #15 was interviewed on 12/01/2022 at 11:36 PM. The LPN stated urinary drainage bags should be covered with a privacy bag when a resident was in or out of their room. The LPN stated she knew Resident #19's urinary drainage bag was uncovered, since the resident remained in the room, but added that when the resident came out of the room the urinary drainage bag was covered. The Director of Nursing (DON) was interviewed on 12/01/2022 at 2:59 PM. The DON stated the facility's policy included covering urinary catheter drainage bags to maintain privacy and dignity. The DON stated she expected staff to follow the policy. The Administrator was interviewed on 12/02/2022 at 10:26 AM. The Administrator stated she thought leaving the urinary drainage bag uncovered was acceptable, as long as the residents remained in their rooms.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		12/15/22

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F 609	Continued From page 4 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility document and policy review, the facility failed to report an injury of unknown origin to the state survey agency (SSA) within the required timeframe for 1 (Resident #28) of 2 sampled residents reviewed for injuries of unknown origin. Findings included:	F 609	1. The investigation and intervention were reviewed on 12/5/22. Results proved to be successful for this resident, with no reoccurrence, and was not affected by the timeliness of reporting. Event reporting requirements were reviewed by the Medical Director with NHA and DON on 12/5/22. 2. An audit of residents with left arm	

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F 609	Continued From page 5 Review of a facility policy titled, "Incident and Reportable Event Management," revised 08/16/2022, revealed, "Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures." The policy defined an injury of unknown source was classified as such when both of the following criteria were met: "The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g. [for example], the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidences of injuries over time." A review of an "Admission Record" revealed Resident #28 had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a nontraumatic intracerebral hemorrhage (bleeding inside the brain) affecting the left dominant side, epilepsy, aphasia, abnormal posture, contracture of the left elbow, and cognitive communication deficit.	F 609	contractures requiring the support of the Golvo lift was conducted. No other were residents identified to be affected. 3. Reportable events will be presented during Grand Rounds which will include event reporting investigation and timeliness of the report. Education was provided to licensed nurses starting 12/7/22 reviewing event reporting requirements and notification to the DON and NHA. 4. The NHA established an event reporting log on 12/15/22 to track timing and completion of any reportable events. An audit of this log and summary will be provided to the Quality Assurance team for the next 90 days for their review and recommendations. The QAPI Committee will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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F 609	Continued From page 6	F 609		

Review of a quarterly Minimum Data Set (MDS), dated 09/26/2022, revealed Resident #28 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident was totally dependent on staff for all activities of daily living (ADLs).

A review of Resident #28's "Care Plan," dated as initiated 03/11/2022, revealed the resident had the potential for impairment to skin integrity related to moving their arms during care. Interventions included assessing the location, size, and treatment of skin injuries; applying a brace to the left arm when the resident was in bed and removing it for bathing and skin checks; and using caution during transfers and bed mobility to prevent striking the resident's arms, legs, and hands against any sharp or hard surface.

A review of an "Incident Audit Report," dated 05/16/2022 at 2:50 PM, revealed Resident #28 had bruising to the upper right side and left arm. Resident #28's left upper arm, shoulder, and left chest were noted to be warm, firm to touch, and swollen, and the resident had a "yellowish discoloration" to the chest area. The Director of Nursing (DON) was notified and assessed the resident.

A review of an untitled document, dated 05/16/2022, revealed the DON was notified of the injury on 05/16/2022 at 3:00 PM.

A review of an "Event Report" revealed the facility completed the initial report of Resident #28's injury of unknown origin to the Office of Health

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F 609	Continued From page 7 Care Assurance (OHCA) on 05/18/2022 at 6:30 PM, over 48 hours after the injury was identified. During an interview on 12/01/2022 at 12:19 PM, the DON stated she was not the DON at the time of the incident. The DON stated the facility had two hours to report the injury after it was found. During an interview on 12/01/2022 at 2:57 PM, Licensed Practical Nurse (LPN) #5 stated if a resident had an injury of unknown origin, she would complete a risk management report and inform the DON, the resident's responsible party, and the resident's doctor. During an interview on 12/02/2022 at 8:23 AM, the Administrator (ADM) stated she was not sure what happened regarding the timing of the report of Resident #28's injury of unknown origin to the state agency. During an interview on 12/02/2022 at 12:06 PM, the ADM stated she was notified of Resident #28's injury on 05/18/2022 by the DON. The ADM stated she would have preferred the injury to have been reported right away, but she was trying to determine what happened. The ADM stated the DON and ADM shared the responsibility for reporting injuries of unknown origin, but Resident #28's injury was reported to the state agency by the DON.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		12/15/22

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F 610	Continued From page 8 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, facility document review, and policy review, it was determined that the facility failed to thoroughly investigate injuries of unknown origin for 2 (Resident #24 and Resident #28) of 2 sampled residents reviewed for injuries of unknown origin. Findings included: Review of a facility policy titled, "Abuse - Conducting an Investigation," dated 10/04/2022, revealed, "When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence." The policy also indicated, "The written summary of the investigation should include, but is not limited to: a. A review of the Incident Report. b. An interview with the person(s) reporting the incident. c. Interviews with any witnesses to the incident. d. An interview with the resident, if appropriate. e. A review of the	F 610	1. The investigations were reviewed on 12/5/22. Resident interventions proved to be successful for both residents, with no reoccurrence. Event reporting requirements were reviewed by Medical Director with NHA and DON on 12/5/22. 2. A review of resident events involving resident transfers or repositioning was reviewed with the Medical Director on 12/5/22 with no other residents identified. 3. A root cause discussion identified the systemic changes needed. Future investigations will be completed with individual electronic notes per investigator to avoid the potential override of investigation notes between interviewers. Reportable events will be presented during Grand Rounds which will include event reporting investigation process. Education was provided to licensed nurses starting 12/7/22 regarding event reporting requirements and notification to the DON and NHA.	

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F 610	Continued From page 9 resident's medical record. f. An interview with the employee(s) as needed. g. A review of the employee's file, as needed. h. Interviews with staff members on all shifts having contact with the resident at the time of the incident. i. Interviews with the resident's roommate, family, and/or visitors who may have information regarding the incident." 1. A review of an "Admission Record" revealed Resident #28 had diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following nontraumatic intracerebral hemorrhage (bleeding inside the brain) affecting the left dominant side, epilepsy, aphasia, abnormal posture, contracture of the left elbow, and cognitive communication deficit. Review of a quarterly Minimum Data Set (MDS), dated 09/26/2022, revealed Resident #28 was severely impaired in cognitive skills for daily decision-making per a staff assessment for mental status. The MDS indicated the resident was totally dependent on staff for all activities of daily living (ADLs). A review of Resident #28's "Care Plan," dated as initiated 03/11/2022, revealed the resident had the potential for impairment to skin integrity related to the resident moving their arms during care. Interventions included assessing the location, size, and treatment of skin injuries; applying a brace to the left arm when the resident was in bed and removing it for bathing and skin checks; and using caution during transfers and bed mobility to prevent striking the resident's arms, legs, and hands against any sharp or hard surface.	F 610	4. The NHA established an event reporting log on 12/15/22 to track timing and completion of any reportable events. An audit of this log and summary will be provided to the Quality Assurance team for the next 90 days for their review and recommendations. The QAPI Committee will determine if substantial compliance has been achieved and the frequency of ongoing monitoring.	

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F 610	Continued From page 10	F 610		

A review of an "Incident Audit Report," dated 05/16/2022 at 2:50 PM, revealed Resident #28 had bruising to the upper right side and left arm. Resident #28's left upper arm, shoulder, and left chest were noted to be warm, firm to touch, and swollen, and there was a "yellowish discoloration" to the resident's chest area. The Director of Nursing (DON) was notified and assessed the resident.

A review of an "Event Report," dated 05/18/2022, revealed Resident #28 had an injury of unknown source. The injury was described as significant bruising to bilateral axilla (both armpits) and yellowing and bruising of the skin to the front, upper chest wall. The report indicated the area to the left side of the upper chest was firm.

A review of "Associate Interview" forms, dated 05/18/2022 and 05/19/2022, revealed Certified Nursing Assistants (CNAs) #25, #26, and #16 were interviewed as part of the investigation of Resident #28's injury of unknown origin.

A review of nursing schedules for 05/13/2022, 05/14/2022, 05/15/2022, and 05/16/2022 revealed there were 27 staff members who may have worked with Resident #28 during the time the injury of unknown origin was likely to have occurred.

During an interview on 11/30/2022 at 11:43 AM, Resident #28's family member stated that the facility said they did not know how Resident #28 got the bruise. The family member indicated they thought that since the left arm was contracted, someone was not gentle enough when applying the brace.

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F 610	Continued From page 11	F 610		

During an interview on 12/01/2022 at 9:27 AM, Licensed Practical Nurse (LPN) #15 denied having been interviewed during the facility's investigation of Resident #28's injuries. LPN #15 stated the nurses put a brace on Resident #28's left arm, and that may have caused the bruising.

A review of "Daily Assignment Sheets" for 05/13/2022 and 05/15/2022 revealed LPN #15 worked with Resident #28 during the days prior to the injuries being identified.

During an interview on 12/01/2022 at 9:34 AM, LPN #27 stated she did not remember if she was interviewed about Resident #28's injury of unknown source. LPN #27 stated she was not sure how Resident #28 got the bruising.

During an interview on 12/01/2022 at 9:39 AM, CNA #29 stated the sling used for showering Resident #28 could have caused the bruising because it went under the armpits and pushed forward when the resident was lifted.

During an interview on 12/01/2022 at 9:44 AM, CNA #17 stated she was interviewed by the Administrator (ADM) about Resident #28's injury of unknown origin. Further review of the "Associate Interview Forms" included in the facility's investigation documentation revealed CNA #17's interview was not included.

During an interview on 12/01/2022 at 9:56 AM, CNA #28 stated she did not recall if she worked with Resident #28 during the time of the identification of the injury of unknown source. CNA #28 stated she was not interviewed as part of the investigation.

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HALE ANUENUE RESTORATIVE CARE	1333 WAIANUENUE AVENUE HILO, HI 96720

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A review of the nursing schedule revealed CNA #28 worked on 05/14/2022.

During an interview on 12/01/2022 at 12:19 PM, the DON stated she was not the DON at the time Resident #28's injuries were discovered. The DON stated the facility should have looked at the daily schedules to see who was assigned for the 72 hours prior to the identification of the bruise.

During an interview on 12/01/2022 at 2:51 PM, CNA #11 stated she was interviewed about Resident #28's injury of unknown source. CNA #11 stated she had seen the bruise and reported it to the nurse.

Further review of the "Associate Interview Forms" included with the facility's investigation documentation revealed CNA #11's interview was not included.

During an interview on 12/01/2022 at 2:57 PM, LPN #5 stated she was interviewed about Resident #28's injury of unknown origin but did not remember what was asked.

Further review of the "Associate Interview Forms" included with the facility's investigation documentation revealed LPN #5's interview was not included.

During an interview on 12/02/2022 at 8:23 AM, the ADM stated she could not find any more documented interviews that were completed as part of the investigation. The ADM stated a lot of people were involved in Resident #28's case because the resident required so much assistance. The ADM stated there should have

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been interviews with staff who had worked with the resident for the 72 hours prior to the identification of the injury.

During an interview on 12/02/2022 at 12:06 PM, the ADM stated the DON was responsible for investigating this injury of unknown origin.

During an interview on 12/02/2022 at 12:27 PM, the DON stated there were assignment sheets on the unit, but that anyone assigned on the Keolamau Unit could have potentially been assigned to work with Resident #28.

During an interview on 12/02/2022 at 12:46 PM, the DON stated they were unable to find all the assignment sheets for the timeframe relevant to Resident #28's injury of unknown source.

2. A review of an "Admission Record" revealed the facility admitted Resident #24 with diagnoses of hypertension and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side.

Review of a quarterly Minimum Data Set (MDS), dated 08/29/2022, revealed Resident #24 was severely impaired in cognitive skills for daily decision-making per a staff assessment of mental status. The MDS indicated the resident was totally dependent for all activities of daily living and had impaired range of motion to both upper and lower extremities.

A review of an "Event Report," dated as initiated 05/18/2022 and completed on 05/23/2022, indicated on 05/18/2022, a licensed nurse assessed Resident #24 and observed

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discoloration and swelling to the resident's left upper extremity. The physician noted a contusion and swelling and ordered a mobile x-ray, which revealed an acute, medially displaced fracture of the proximal left humerus. No resident witness statements were included with the facility's investigation.

During an interview on 12/02/2022 at 9:00 AM, the Director of Nursing (DON) indicated the Administrator was responsible for abuse investigations. The DON indicated social services was also involved. The DON revealed she was responsible for the clinical aspect of an abuse investigation.

During an interview on 12/02/2022 at 9:39 AM, Social Services Assistant (SSA) #9 indicated it was his responsibility to obtain resident witness statements for certain types of investigations. SSA #9 indicated he remembered obtaining resident witness statements for Resident #24's investigation but stated he was unable to locate the resident witness statements.

During an interview on 12/02/2022 at 11:01 AM, the Administrator indicated part of the investigation process was for her and SSA #9 to obtain the interviews. The Administrator indicated she had conducted the staff interviews and SSA #9 had done the resident interviews related to the investigation of Resident #24's injury. The Administrator revealed she had not located the resident witness statements. The Administrator indicated the resident witness statements should be available.

During an interview on 12/02/2022 at 1:01 PM, the DON indicated resident witness statements

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F 610	Continued From page 15 should be maintained with the investigation. The DON indicated her expectation was that resident witness statements were to be kept in a file with the rest of the investigation documentation. During an interview on 12/02/2022 at 1:02 PM, the Administrator indicated her expectation was for resident witness statements to be obtained and maintained for all investigations.	F 610		
F 812 SS=F	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 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 observations, interviews, facility policy review, and document review, the facility failed to ensure potentially hazardous cold food items were held at a temperature of 41 degrees Fahrenheit (F) or lower during tray line service for	F 812	1. No residents were identified to have been impacted by the food temperatures or cleaning practices noted. On 11/30/22 the clipboard was cleaned, the walls in the preparation area and the fan were deep	12/23/22

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F 812	Continued From page 16 2 of 2 meals observed. Additionally, the facility failed to ensure surfaces and equipment were maintained in sanitary condition in 1 of 1 kitchen. The deficient practices had the potential to affect all 90 residents who received food and/or beverages from the kitchen. Findings included: 1. Review of a facility policy titled, "Food Temperature Control," dated 04/27/2022, revealed, "Food temperatures are maintained during serving times to ensure residents receive safe food served at acceptable temperatures." The policy also indicated, "Food temperatures are checked at the completion of the cooking process and before being placed on the serving line; if issues are identified, they are corrected, or the food is discarded." Additionally, the policy indicated the following: - "Potentially Hazardous Food (PHF) or Time/Temperature Control for Safety (TCS) Food means food that requires time/temperature control for safety to limit the growth of pathogens (i.e. [such as] bacterial or viral organisms capable of causing a disease or toxin formation). - "Cold foods are held at or below 41 [degrees F] or per state requirements." - "While PHF/TCS Foods are on the serving line, the temperature of the foods will be maintained at a safe temperature." During a concurrent observation and interview on 11/29/2022 at 12:01 PM, the Food Service Director (FSD) was asked to check the temperature of items on the food line. The FSD measured the temperature of egg salad and the temperature registered 51 degrees F.	F 812	cleaned. The speaker was removed from the food preparation area on 12/1/22 because it was mounted to the wall and needed to be removed by Maintenance. 2. No residents were identified to have been impacted by the food temperatures or cleaning practices noted or since the date of the survey. Although food was out of range during meal service, it was still within the 4 hour food safety window per Food Code for food safety. 3. Associates identified during the observation received 1:1 written education from the FSD on 11/29/22. In addition, the FSD provided an all dietary staff in-service on 12/1/22 educating staff on the policy regarding preparing, storing and distributing foods at safe temperatures. In-service included, but was not limited to appropriately preparing and storing cold foods (for example: submerged in ice, prepare in advance to allow for adequate cooling, etc.) In the event cold foods exceed 41 degrees prior to the start of meal service, the food item will be re-chilled to proper temperature. The FSD contacted the Divisional Dietitian on 11/29/22 to validate his understanding of current practices and expectations. The walls, clipboards and fans were all added to routine cleaning schedules. Training regarding food temperatures and cleaning practices, focusing on food safety to ensure foods are stored, prepared and distributed safely were reviewed again during a regular all dietary staff meeting on 12/16/22. The PM cook will complete the cooks closing checklist each night and the FSD or designee will	

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F 812	Continued From page 17 During an interview on 11/30/2022 at 8:23 AM, the FSD stated staff would start placing potentially hazardous cold foods in the refrigerator before serving. The FSD stated if a cold item was not below 41 degrees F, it should be chilled or pulled from another source. During an interview on 11/30/2022 at 8:38 AM, the FSD stated the temperature of the egg salad was not recorded before or after the tray line. During a concurrent observation and interview on 12/01/2022 at 8:26 AM, Dietary Employee (DE) #20 checked the temperature of a pre-poured cup of chocolate milk that was on the tray line. The temperature of the milk was 46.9 degrees F. DE #20 stated the temperature was supposed to be below 40 degrees F. During an interview on 12/01/2022 at 3:07 PM, the Administrator ADM stated the FSD was responsible for ensuring temperatures were checked on the tray line. The ADM stated if an item was not the appropriate temperature, it should have been pulled off the line. 2. Review of a facility policy titled, "Cleaning Schedule," dated as reviewed 04/27/2022, revealed, "Procedure 1. The Director of Food and Nutrition Service develops a cleaning schedule to include all equipment and areas to be cleaned. 2. Designated cleaning tasks are assigned to each position. 3. The cleaning schedule is posted in a location where it can be easily read. 4. The Director of Food and Nutrition Service monitors the cleaning schedule to ensure the tasks are completed timely and appropriately." Review of an undated "Dietary Security Checklist"	F 812	conduct weekly department reviews to ensure food safety, and cleaning is being completed per cleaning schedules with accurate documentation. 4. The FSD will conduct random audits 3 x per week of food temperature and cleanliness of the kitchen to ensure food safety. The FSD will provide the outcomes of his audits to the Quality team monthly for at least 3 consecutive months or until QAPI team determines sustained compliance.	

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revealed, "Refrigerator and freezer units are clean and neat and locked."

During an observation on 11/29/2022 at 3:34 PM, the fan in the food preparation area and two fans above the clean drying rack in the dishwashing area were covered in dust.

On 11/30/2022 at 8:32 AM, a clipboard hanging on the wall in the food preparation area was observed to be covered in dust. Dust was observed on the wall in the food preparation area.

On 11/30/2022 at 8:40 AM, the wall behind the fan in the food preparation area was observed to be covered in dust. The wall behind the fan in the dishwashing area was also covered in dust. A speaker on the same had a thick accumulation of dust on top of it. The wall underneath the dish machine was soiled with food debris. The wall and ceiling tiles above the dish washing area were observed to be covered with dust. Cobwebs were observed behind the shelf next to the first walk-in refrigerator.

On 11/30/2022 at 8:44 AM, the floor of the reach-in freezer was observed to be covered in food crumbs.

During an interview on 11/30/2022 at 8:32 AM, the Food Service Director (FSD) was unable to locate the cleaning schedule. The FSD stated the person who did the security check off at the end of the shift had to check off that everything was clean before they locked up. The FSD acknowledged it was his responsibility the past two nights.

During a concurrent observation and interview on

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F 812	Continued From page 19 11/30/2022 at 8:50 AM, the FSD observed the areas with dust in the kitchen and the freezer and stated that cleaning needed to be done. The steam table was observed to have food debris accumulated. During an observation on 12/01/2022 at 8:24 AM, dust and debris remained on the fans, walls, ceiling, and in the reach-in freezer as previously described. During an interview on 12/01/2022 at 3:07 PM, the Administrator (ADM) stated there was a cleaning list and schedule in the kitchen. The ADM stated the FSD was responsible for ensuring the cleaning was done.	F 812		