STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315153	A. BUILDING ______ B. WING ______	09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR, THE	689 WEST MAIN ST FREEHOLD, NJ 07728

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F 000	INITIAL COMMENTS STANDARD SURVEY: 09/09/19 CENSUS: 89 SAMPLE SIZE: 21 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		10/30/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/27/2019

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 657	Continued From page 1 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed revise the fall care plan for a resident who sustained a fall. This deficient practice was identified for 1 of 1 resident reviewed for falls and was evidenced by the following: On 09/04/19 at 11:47 AM, the surveyor observed Resident # 8 at the lunch meal. The lunch meal was in front of the resident and the resident had his/her head faced downward and was not initiating self-feeding. On 09/04/19 at 12:48 PM, the surveyor interviewed the Certified Nurse Aide (CNA #1) assigned to provide care to the resident. CNA #1 stated that the resident was sleepy today and that the resident had a fall on Monday (09/02/19). She continued to state that if the resident was left alone, the resident can and will try to stand up and because of that reason the resident is kept at the nurses station. CNA #1 added that on the day the resident fell, the Unit Manager (UM) was not working. According to the Profile Face Sheet (an admission summary), Resident #8 was admitted to the facility on [redacted] with diagnoses that included [redacted] An Admission Nursing Evaluation, dated [redacted], revealed an admitting diagnoses of [redacted] A Risk Assessment for Falls, dated	F 657	1. It was determined that resident #8 had a recent fall and the care plan was not updated with interventions in a timely manner. Upon hearing of the incident the Director of Nursing reviewed and revised the fall care plan for resident #8. A root cause analysis was completed to identify the cause of the deficient practice which revealed that the Unit Manager failed to review care plan for update after the fall and a second check was not in place to ensure follow up. 2. All residents have the potential to be affected by this deficient practice. The Director of Nursing and Unit manager audited all charts on the unit; no additional resident care plan was found to be in need of an update. 3. The Director of Nursing or Administrator will receive notification of falls by phone and will ask at time of call if care plan was updated. Director of Nursing or designee will review each fall within 24 hours to ensure compliance of updated care plan and ensure the update is noted in our incident computer system. All nurses were in-serviced 9/04/19 on the policy for care plan revision to include new interventions to be initiated when there is a resident fall and to ensure a call to Director of Nursing or Administrator alerting of the fall. A nurse competency checklist for accidents and incidents will be created and utilized. 4. Director of Nursing or designee will	

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F 657	Continued From page 2 11/26/17, revealed that the resident had a score of 30 and a resident "receiving a score of ten or greater will be classified as a potential fall candidate." A review of the Minimum Data Set (MDS), an assessment tool used to facilitate care dated [redacted] revealed that Resident #8 had a Brief Interview of Mental Status (BIMS) of [redacted] The MDS also revealed that the resident was not steady when moving from a seated to standing position and was only able to stabilize with staff assistance. On 09/05/19 at 8:25 AM, the surveyor observed the resident sitting in a wheelchair at a table located in front of the nurses station on the South side eating breakfast. Concurrently, the surveyor interviewed the UM who stated that the resident was at a high risk for falls, had a history of falls and that the Certified Nurse Aide (CNA) puts the resident at the nurses' station after breakfast so that he can watch the resident. He continued to state that unfortunately he was not working on the Monday (09/02/19) that the resident fell. At that time, the surveyor reviewed Resident #8's Interdisciplinary Plan of Care (IDCP) with the UM. The IDCP, Potential For Falls, revealed that the document was a pre-printed care plan, updated on 12/18. Under the section "Problems/Strength, Potential for falls related to:" the following boxes were checked off: "History of falls, Impaired balance, Impaired coordination, Unsteady gait, Desire to maintain independence and cognitive impairment." Underneath the problem list, there was a handwritten entry that reflected on "9-2-19 Found on floor at nurse's station." Under the	F 657	audit the care plans of all falls monthly to ensure follow up and care plan update. Director of Nursing will report the result of the monthly audits to the QAPI committee on a monthly basis for monitoring.	

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F 657	Continued From page 3	F 657		

"Interventions/Approaches" section on the IDCP, the following boxes were checked off: "Keep call bell within reach, PT/OT (physical therapy/occupational therapy) as ordered, Keep area clutter free, Fall risk assessment, Bed in lowest potion as tolerated, Floor mat next to bet, Anticipate needs if unable to use call bell" and under "Provide appropriate assistive device," wheelchair was handwritten in. There were no new interventions identified on the IDCP for falls, nor was the intervention described by the UM and CNA #1, to leave the resident at the nurses station, listed on the IDCP.

The UM confirmed that having the resident sit at the nurses station was not part of the IDCP for falls and acknowledged that the IDCP for falls was not updated with new interventions after the resident's recent fall. He continued to state that everyone knew that the resident should be watched, however, he could not offer an explanation as to why leaving the resident at the nurses station was not part of the IDCP for for falls, nor what should be done when the UM was not available to watch the resident.

The surveyor reviewed two Fall Investigation Forms (FIF) for Resident #8. One was for a fall that occurred on 07/22/18 and one for a fall that occurred on 09/02/19. The FIF for the fall that occurred on 07/22/18 revealed that the resident was in front of the nursing station at a table and fell from his/her wheelchair. The document revealed that the fall was unwitnessed and the resident was found by a CNA who noticed that the resident was on the floor. The wheelchair was found on its side.

The FIF for the fall that occurred on 09/02/19

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F 657	Continued From page 4	F 657		

revealed that the resident had an unwitnessed fall and was found lying on the floor in front of the nurses station and the wheelchair was found tipped over. The resident sustained [redacted]. Under recommendation, frequent monitoring to assist with needs was checked off and under other, continue with current fall prevention program was handwritten in on the form.

On 09/05/19 at 1:00 PM, the surveyor, in the presence of the survey team, interviewed the DON regarding the IDCP for Falls for Resident #8. The DON stated that the resident was supposed to have intermittent supervision, although it is not on the care plan. Additionally, she acknowledged and confirmed that there were no new interventions in place to lessen the possibility of the resident falling again and it was expected that the nurses should have updated the IDCP immediately after the resident fell. She did not offer an explanation as to why the care plan interventions were not updated despite the resident sustaining two falls at the nurses' station.

On 09/06/19 at 1:44 PM, the surveyor interviewed the UM regarding the presence of a facility fall program. The UM stated we don't have one. He continued to state we have interventions for each resident. The interview continued regarding the communication process for new interventions that may be added to the IDCP for a resident after a fall He stated that communication would occur in the morning, before the staff would begin an assignment. He further stated that there has been no new interventions added for fall prevention to Resident # 8. The surveyor reviewed the CNA Care Card for Resident #8 with

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F 657	Continued From page 5 the UM. The Care Card revealed under Safety & Fall Prevention, 1/2 side rails, Floor Mat and Low Bed and the resident was checked off as a high fall risk. There were no interventions or instructions regarding leaving the resident at the nurses' station. The Incident Accident Protocol Policy, revised 05/12/17, revealed,,Under section 4.3 and 4.3.3, that unwitnessed falls require a timely investigation with a 24 hour look back by the Administrator, DON, Charge Nurse or Supervisor. Under section 4.5 and 4.5.2, when conducting an investigation the administrator, DN or designee should initiate actions to prevent further incidents. On 9/09/19 at 10:40 AM, the Administrator stated that she had no additional information to provide other than the responses that were previously provided by DON in regards to Resident #8. NJAC 8:39-11.2(h)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to 1.) follow a physician's order for a	F 658	1. It was determined that the facility failed to follow a physician□s order for a for resident #23. Upon hearing of this incident Director of Nursing and Unit Manager had completed	10/30/19

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F 658	Continued From page 6 [redacted] and 2.) follow the facility policy for completing neuro-checks. This deficient practice occurred for 2 of 21 residents reviewed for physician orders, Resident #23 and Resident #8 and was evidenced by the following: Reference: New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities with in the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. According to the Admission Record, Resident #23 was admitted to the facility on [redacted] and had medical diagnoses that included [redacted]	F 658	for resident #23. A root cause analysis was completed to identify the cause of the deficient practice which revealed that the process for ensuring [redacted] were completed was not standardized, nor was a process put in place for communication between the Unit Manager and others to follow up. 2. All residents with [redacted] have the potential to be affected. The Director of Nursing and Unit manager completed audits on all residents who have orders for [redacted] [redacted], no other residents were affected by this deficient practice. 3. Upon admission all residents requiring [redacted] will be noted on the [redacted] worksheet located at the nurse□s station so others have access. The order for [redacted] will be blocked off on the medication administration record. All nurses were in-serviced on 9/05/19 of the new process and where to find the [redacted] worksheet. The worksheet will be checked monthly for [redacted] coming up 4. Unit Manager or 11-7 Supervisor will audit [redacted] worksheet monthly and report to Director of Nursing or designee. Director of Nursing will audit the Medication Administration Record to ensure it is blocked off on a monthly basis and will report the result of the audits to the QAPI committee on a monthly basis for monitoring. 1. It was determined that the	

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F 658	Continued From page 7 [redacted] Review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the staff assessed the resident as having [redacted]. On 09/03/19 at 9:52 AM, the surveyor observed Resident #23 sleeping in bed. On 09/04/19 at 12:25 PM, the surveyor reviewed the resident's medical record which revealed the following: Review of the September 2019 Physician Order Sheet (POS) for Resident #23 revealed a physician's order, dated 07/16/17, for [redacted] every 4 months (March, July, Nov)." Review of the The March 2019 Treatment Administration Record (TAR) reflected a corresponding physician order, dated 07/16/17, for [redacted] every four months (March, July, Nov). The surveyor also observed a handwritten "FYI" [for your information] that was documented in the hour section of the physician order and the remaining area in the TAR was blank. A specific date for the [redacted] [redacted] was not documented on the TAR. Review of the July 2019 TAR reflected the corresponding physician order, dated 07/16/17, for [redacted] every four months (March, July, Nov). The surveyor observed a handwritten line under July and a "FYI" was documented in	F 658	un-witnessed fall investigation guidelines for neuro checks were not followed according to facility policy. Upon hearing this, the Director of Nursing and Unit Manager initiated another 48 hour neuro check for resident #8 to complete the 72 hour check. A root cause analysis was completed to identify the cause of the deficient practice which revealed that the nurse was confused and thought it was a 24 hour check instead of a 72 hour check, upon further investigation it was revealed that there was conflicting instructions between an older and a newer policy. 2. All residents sustaining an un-witnessed fall have a potential to be affected by this deficient practice. The Director of Nursing and Unit Manager audited all charts on unit, no other residents were affected. 3. All nurses□ In-serviced on 9/05/19 on the facility□s correct policy for neuro check for 72 hours on all un-witnessed falls, any other policies were deleted from the system and all staff educated to remove any copies remaining. The Director of Nursing or Administrator will receive notification by phone alerting of the fall at which time they will ask if 72 hour neuro check has been initiated. A nurse competency checklist for accidents and incidents will be created and utilized. 4. Unit manager will conduct weekly audits of the un-witnessed fall 72 hour neuro check work sheet located at the nurses station to ensure it has been completed. As a second check the Director of Nursing or designee will audit the charts of residents who had	

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F 658	Continued From page 8 the hour section of the physician order and the remaining area in the TAR was blank, A specific date for the [redacted] was not documented on the TAR. Review of the resident's Care Plan (CP), initiated on 06/11/18, revealed a "Problem/Strength" of [redacted] The CP further reflected an intervention for scheduled [redacted] as ordered physician every four months. Review of the Nurses' Notes completed in March 2019 and July 2019 failed to reveal documentation that Resident #23's [redacted] was completed Review of the [redacted] Follow Up Report, dated 12/27/18, revealed the last [redacted] was completed on 12/27/18. On 09/05/19 at 9:51 AM, the surveyor interviewed the Unit Manager (UM) regarding the completion of [redacted] for Resident #23 . The UM stated the last [redacted] for the resident was completed in December 2018. UM further stated Resident #23 was due to have a [redacted] in April 2019, but it was not completed. The UM continued to state that he documents the date in a calendar located at the nurses' desk and the nurses are supposed to check the calendar to see when the resident's [redacted] was to be completed. The UM confirmed that Resident #23 did not have a [redacted] completed in July 2019. The UM also stated that the physician's order was documented on the March 2019 and July 2019 TARs as an FYI and	F 658	un-witnessed falls weekly to ensure the 72 hour checks are documented. The results of the audits will be reported to the QAPI committee on a monthly basis for monitoring.	

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F 658	Continued From page 9 confirmed that the date for the [redacted] was not documented on the TAR. The UM further stated he would call the [redacted] company and have Resident #23's [redacted] completed. On 09/05/19 at 11:48 AM, the surveyor observed the UM transporting Resident #23 toward the nursing station. Upon interview, the UM stated he was taking the resident to get his/her [redacted] completed. On 09/09/19 at 10:14 AM, the surveyor interview the Licensed Practical Nurse (LPN #1) who stated that the UM documents the [redacted] dates in a calendar located at the nursing station. She stated the UM was responsible for completing the [redacted] and that the [redacted] are also documented on the TAR as an FYI; however, the dates were not documented. She further stated the nurse on duty is supposed to check the calendar and follow through with completing the [redacted] if the UM was not present. On 09/09/19 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) who stated the [redacted] were documented as an FYI for Resident #23 and the regular nurse did not see it because the date was not blocked off on the TAR. The DON further stated the UM documented the dates for the [redacted] on a calendar and she and the Assistant Director of Nursing (ADON) were responsible when the UM was not present; however, she was unaware of where the calendar was located on the unit. The facility's '[redacted] policy, with an implemented date of 6/17, revealed that residents	F 658		

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F 658	Continued From page 10	F 658		

with [redacted] should be routinely monitored as ordered by the physician.

2. On 09/04/19 at 11:47 AM, the surveyor observed Resident #8 during the lunch meal. The resident's head was down and was not initiating self-feeding.

On 09/04/19 at 12:48 PM, the surveyor interviewed the primary Certified Nurse Aide (CNA #1) assigned to the resident. CNA #1 stated that the resident had a fall while seated in a wheelchair at the nurses' station on Monday (09/02/19). CNA #1 added after she washed and dressed the resident, she wheeled the resident to the nurses' station for supervision. She stated the resident stood up from the wheelchair and then fell and hit his/her head on the the back of the cabinet.

On 09/04/19 at 1:18 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #8. The LPN stated that the resident was sleepy today and she did not know why. She stated that the resident had a fall two days ago (Monday, 09/02/19). The LPN stated that the resident tried to get up unassisted and fell at the nurses' station. She stated that when the resident fell, he/she hit her head on the back of a cabinet and had a bump on the back of his/her head. She continued to state that we did neuro checks (neurological assessment to determine level of consciousness) for 24 hours.

Review of the Nurse Notes (NN), dated 09/02/19 at 9:25 AM, revealed that the resident sustained a fall. The NN, dated 09/02/19 at 3:15 and 9:00 PM, revealed that neuro checks were in progress

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F 658	Continued From page 11	F 658		

and no additional neuro-check documentation was observed, nor was it observed in the Medication Administration Record or the TAR.

Review of the Physician Orders, dated 09/02/19 at 10:00 AM, revealed an order for an [redacted] There were no orders for neuro-checks reflected on the order sheet.

On 09/05/19 at 8:25 AM, the surveyor interviewed the UM regarding the fall sustained by Resident #8. The UM stated the resident's physician had not yet come to evaluate the resident and that neuro-checks had been done for 24-hours after the fall. The UM stated that the physician does not write neuro-check orders.

Review of a Fall Event Summary, dated 09/02/19, revealed documentation of [redacted] [redacted]" and "neuro checks initiated."

Review of the Incident Accident Protocol Policy, revised 05/12/17, under 2.1.4 revealed, "Any customer sustaining an injury to the head and/or has an unwitnessed fall which the customer is unable to describe, should be observed for neurological abnormalities by performing neuro-checks for 48 hours after the incident. The physician should be notified for abnormal findings."

On 09/05/19 at 1:06 PM, the surveyor interviewed the DON regarding the policy for neuro-checks. The DON could not explain why the neuro-checks on Resident #8 were not completed for 48-hours, in accordance with the facility policy.

NJAC 8:39-11.2(b), 27.1(a)

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	315153	A. BUILDING ______ B. WING ______	09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR, THE	689 WEST MAIN ST FREEHOLD, NJ 07728

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F 812	Continued From page 12	F 812		
F 812 SS=D	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 observation, interview and document review, it was determined that the facility failed to a.) maintain potentially hazardous foods stored in a refrigerated unit at appropriate temperatures to prevent potential microbial growth, and b.) label and date potentially hazardous foods with a use by date, and maintain food service equipment intact. This deficient practice was evidenced by the following: On 09/03/19 at 9:00 AM, the surveyor completed an initial tour of the kitchen with the Dietary Director (DD) and observed the following:	F 812	1. In the walk-in refrigerator, there was a half pan with sliced lettuce and tomato with a slice of cheese that was wrapped in plastic wrap sitting on top of the vegetables. The plastic wrapped cheese had the handwritten date of 9/1. The Director of Dining Services stated that the dating policy is 2 days after the food is prepped. The item was re-wrapped immediately and labeled correctly. A root cause analysis was completed to identify the cause of the deficient practice which revealed that the current labeling practices in place were insufficient.	10/30/19

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F 812 Continued From page 13

1. In the walk-in refrigerator, there was a 1/2 pan with sliced lettuce and tomato with a slice of cheese, that was wrapped in plastic wrap, sitting on top of the vegetables. The plastic wrapped cheese contained a handwritten date of 9/1. The DD stated the dating policy was for two days after the food was prepped, it will be discarded.

2. A 1/2 pan of raw chicken breasts was not fully covered and contained liquid in the pan. The chicken did not contain a date. The DD stated the chicken should have been labeled with a pull date and use by date.

3. The chicken breasts were resting on top of a 1/2 pan containing a plastic bag, identified as chicken tenders by the DD. There was no label or date on the bag.

4. A rack, identified as containing clean equipment, contained three 8.75 gallon, large plastic bins. All of the bins had areas with broken corners and one of the corners fell off when the bin was lifted up.

5. A bag of feta cheese was opened, wrapped and dated 8/25. The bag did not contain a use by date.

On 9/5/19 at 10:36 AM, the surveyor toured the kitchen with the DD. The Registered Dietitian (RD) joined the tour at 10:47 AM and the following was observed:

1. A refrigeration unit, located at the end of the resident tray line was opened on top to reveal varied cold cut items. The DD stated the unit was used at meal times to prepare sandwiches as

F 812

2. All residents may be affected by poor food storage practices. The walk-in refrigerators and all storage areas were inspected to ensure all food items were labeled correctly and within the safe date range to store.

3. Initiated a new labeling system to include item name, production date, and expiration date, and put in place a standardized policy for labeling and dating. In-services were completed on September 6th, 2019 and included all dining service staff members. A competency evaluation for all levels of staff will be used to ensure all are aware each year of the expectations of their position.

4. The system will be audited daily by the cook checking for correctly labeled and dated foods in the walk-in refrigerator. The Director of Dining Services will audit the walk-in refrigerator weekly. The audits will be brought to the QAPI committee to be reviewed and monitored on a monthly basis.

1. A half pan of raw chicken breast was not fully covered and contained liquid un the pan. The chicken did not contain a date. The Director of Dining Services stated that the chicken should have been labeled with a pull date and a use by date. A bag of feta cheese was opened, wrapped, and dated 8/25. The bag did not contain a use by date. Another half pan

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F 812	Continued From page 14	F 812		

needed. The top area contained a small pan of egg salad, tuna salad, ham that was prepared in three slice units and contained in a pan, and a small piece of wrapped Swiss and American cheese. The RD and DD confirmed that there was no thermometer located on top of the unit where the sandwich items were stored, nor was the temperatures of the food items monitored. The surveyor utilized a calibrated thermometer to check the temperatures of the the egg salad and three slices of ham. The egg salad was 42.7 degrees Fahrenheit (F) and the ham was 44 degrees F. The DD confirmed the food was out of the acceptable temperature range.

Review of a Standards of Operation Policy for Dining Services, dated 06/18/18 revealed "cold food items are maintained and served at 42 degrees or below. The policy reflected to tightly cover wrap all food items and to label and date. The policy also indicated that "Dining Service Department participates in an ongoing preventive and corrective maintenance program. Small wares and equipment are checked routinely for service issues and repaired or replaced as needed."

NJAC 8:39 17.2(g)

contained a vacuumed sealed plastic bag, identified as chicken tenders by the Director of Dining Services. There was no label or date on the bag. The raw chicken, the feta cheese and the chicken tenders were all removed from the walk-in refrigerator and discarded immediately. A root cause analysis was completed to identify the cause of the deficient practice which revealed that the current labeling practices in place were insufficient.

2. All residents may be affected by poor food storage practices. The walk-in refrigerators and all storage areas were inspected to ensure all food items were labeled correctly and within the safe date range to store.

3. Initiated a new labeling system to include item name, production date, and expiration date and put in place a standardized policy for labeling and dating. In-services were completed on September 6th, 2019 and included all dining service staff members. A competency evaluation for all levels of staff will be used to ensure all are aware each year of the expectations of their position.

4. The system will be audited daily by the cook checking for correctly labeled and dated foods in the walk-in refrigerator. The Director of Dining Services will audit the walk-in refrigerator weekly ensuring labeling and dating is correct. The audits will be brought to the QAPI committee to be reviewed and monitored on a monthly

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F 812

basis.

1. A rack, identified as containing clean equipment, contained 3- 8.75 gallon, large plastic bins. All of the bins had areas with broken corners and one of the corners fell off when the food bin was lifted up. Storage bins were immediately disposed of. A root cause analysis was completed to identify the cause of the deficient practice which revealed that staff training and encouragement could be used to assist the Director of Dining Service when items are damaged and need to be replaced. It also revealed that the current monthly audit completed by the Dietician required more specificity of items.

2. All residents may be affected by poor food storage practices. The Director of Dining Services made a thorough inspection of all plastic service items to ensure none of the remaining bins had any chips or cracks.

3. Plastic service items will now be specified on the monthly food safety and sanitation audit completed by the Dietician or designee for compliance. Staff was in-serviced on September 6th, 2019 to help with the compliance. A competency evaluation for all levels of staff will be used to ensure all are aware each year of the expectations of their position.

4. Director of Dining Services or designee will audit the monthly checks on

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F 812	Continued From page 16	F 812	a quarterly basis to ensure all items were checked as specified and will be brought to the QAPI committee monthly for review and monitoring. 1. A refrigeration unit, located at the end of the resident tray line was opened on top to reveal varied cold cup items. The DD stated the unit was used at meal times to prepare sandwiches as needed. The top area contained a small pan of egg salad, tuna salad and ham that was prepared in three slice units and contained in a pan, with a small piece of wrapped Swiss and American cheese. The Dietician and the Director of Dining Service confirmed that there was no thermometer located on top of the unit where the sandwich items were stored, nor were the temperatures of the food monitored. The surveyor utilized a calibrated thermometer to check the temperatures of the egg salad and three slices of ham. The egg salad was 42.7 (F) and the ham was 44 degrees (F). The Director of Dining Service confirmed the food was out of the acceptable range. All products in the open-air refrigeration unit were discarded immediately and refrigeration unit taken out of service. A root cause analysis was completed to identify the cause of the deficient practice which revealed the refrigeration unit was faulty. 2. All residents may be affected by poor food storage practices. A commercial	

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F 812	Continued From page 17	F 812	refrigeration repair company was called immediately to check the unit and found that the thermostat was sticking on both high and low temperatures. New part ordered, and installed on 9/17/19. Upon repair, unit is operational to the specifications of the unit. 3. Purchased pan mounted, dial bi-metallic thermometers to place in the food products to maintain on-demand product temperatures while stored and in service. Temperature logs have been developed to monitor cold food items stored in this unit to be taken and recorded by day and evening shift food service workers. In-services were completed on September 6th, 2019 and included all dining service staff members. A competency evaluation for all levels of staff will be used to ensure all are aware each year of the expectations of their position. 4. Temperatures will be checked weekly by the Director of Dining Service or designee to ensure the new practice is working. The temperature logs and the audit will be reported to the QAPI committee by the Director of Dining services on a monthly basis for review and monitoring.	