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	345447	A. BUILDING _____ B. WING _____	C 09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE CENTER	**25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804**

(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 No deficiencies were cited as a result of the complaint investigation Event ID #B2ZL11.	F 000		
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 record review and staff interviews, the facility failed to follow a physician's order to discontinue a medication resulting in 10 additional doses for 1 of 5 sampled residents reviewed for medications (Resident #24). Finding included: Resident #24 was admitted to the facility on 11/14/17 with diagnoses that included gastro esophageal reflux disease (GERD), dementia, depression, and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 07/13/18 coded Resident #24 with moderate impairment in cognition and required extensive staff assistance with most Activities of Daily Living (ADL) including bed mobility, transfer, toilet use and personal hygiene. The MDS indicated Resident #24 had no histories of rejection of care and swallowing disorder. Review of physician's order dated 07/27/18 revealed Prilosec 20 milligrams (mg) 1 tablet by mouth daily for 30 days for GERD was ordered	F 658	After performing an internal root-cause analysis, it was determined that there was not an effective system in place for ensuring the accurate transcription of medications with a specified stop date from month to month on the MAR. Resident #24□s Prilosec orders were reviewed by physician, orders received/initiated. 2)Director of Nursing, Unit Managers and Assistant Director of Nursing have completed a Quality Review of current resident Medication Administration Records (MARS) for accurate transcription of medication with specified stop dates. Follow up based on findings 3) The Nursing staff was re- educated by the Director of Nursing with regards to accurate medication transcription with a special focus on medications ordered with a specific stop date. 4) The Director of Nursing will be responsible for implementing this plan of correction. The Director of Nursing introduced the plan of correction to an Ad	10/1/18

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

Electronically Signed | 09/27/2018

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F 658	Continued From page 1 for Resident #24. Further review of the physician's order indicated the order had been signed by the physician and a note stated "Noted & faxed" was written on the order sheet. Review of Medication Administration Records (MAR) revealed Resident #24 received the first dose of Prilosec 20 mg once daily on 07/28/18 and continued to receive it through 09/05/18. Resident #24 had received a total of 40 days of Prilosec 20 mg instead of 30 days as specified in the order by 09/05/18. During an interview on 09/05/18 at 05:45 PM Nurse #3 stated according to the physician's order, the Prilosec should be discontinued by 08/26/18. To her best knowledge, the Prilosec order that was written on 07/28/18 for Resident #24 was the only Prilosec order she could find in the medical records. Nurse #1 added whenever the new MAR rolled out each month, the night shift nurse would audit the order for accuracy and set a stop date to ensure the order would be stopped in a timely manner. During an interview on 09/06/18 at 10:11 AM Nurse #2 acknowledged that the Prilosec order should be stopped after 30 days as ordered. She could not find any other Prilosec order in Resident #24's medical record other than the one written on 07/27/18. During a phone interview on 09/06/18 at 10:29 AM the Nurse Practitioner (NP) stated she had written the initial Prilosec order on 07/27/18 for a 30 days therapy. The NP recalled she had evaluated Resident #24 on 08/10/18 and she might have called in a verbal order to extend the Prilosec therapy indefinitely as she felt Resident	F 658	Hoc QAPI committee meeting on 9.19.2018. Director of Nursing/ADON/Unit Managers to complete random Quality Improvement Monitoring of resident MARS for accurate transcription of medications with specified stop dates using a sample size of 5 residents 5x/week x 2 weeks, weekly x 4 weeks, and then monthly and as needed. Findings are to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. The QAPI Committee consists of, but not limited to: Medical Director, Executive Director, Director of Nursing, and Assistant Director of Nursing, Activities Director, Social Services Director, Maintenance Director, Dietary manager, MDS nurse and direct care givers.	

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F 658	Continued From page 2	F 658		

#24 was benefiting from the therapy.

Review of progress notes dated 08/10/18 revealed Resident #24 was seen by the NP due to increased nasal drainage. However, Prilosec therapy that extended beyond 30 days was not mentioned in the progress notes during this visit.

During a phone interview on 09/06/18 at 02:26 PM the Consultant Pharmacist stated the pharmacy had received the faxed order of Prilosec 20 mg 1 tablet by mouth once daily for 30 days for Resident #24 on 08/12/18 from the facility. However, the order was written on 07/27/18 and that was the only Prilosec order the pharmacy had received for Resident #24. The Consultant Pharmacist denied the pharmacy had received any Prilosec order from the facility on 07/27/18.

During an interview on 09/06/18 at 04:29 PM the Director of Nursing (DON) acknowledged that the facility had failed to fax the initial Prilosec order to the pharmacy in a timely manner and failed to stop the Prilosec after the 30 days therapy. It was her expectation for the nursing staff to follow physician's order to stop the medication as ordered after 30 days unless the physician stated otherwise. The DON also expected the nursing to document and fax physician's order in a timely manner to avoid confusion.

During an interview on 09/07/18 at 09:18 AM the Medical Director (MD) stated the physician's order should be followed and the Prilosec order should be discontinued after 30 days as ordered. The MD denied there were any harmful effects for Resident #24 to receive 10 more days of Prilosec therapy.

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, and Nurse Practitioner interviews the facility failed to assess a resident who was observed to have milk colored secretions after an episode of emesis (a medical term used for vomiting) followed by coughing/gagging for 1 of 1 resident reviewed for a tracheostomy (Resident #93). Findings included: Resident #93 was admitted to the facility 06/08/18 with diagnoses which included respiratory failure and aphasia (total absence of ability to form speech). A review of the admission Minimum Data Set (MDS) dated 06/15/18 assessed Resident #93's cognitive skills as severely impaired for daily decision making. The assessment included the functional status as being totally dependent on staff for bed mobility and eating. The MDS identified swallowing disorders which included coughing/choking during meals and receiving 51% or more calories and fluids through a feeding tube. Special treatments included suctioning and tracheostomy (an incision located	F 684	After performing an internal root-cause analysis, it was determined that there was not an effective system in place for the completion of nursing assessments involving the potential aspiration of feeding formula for a tracheostomy resident. Resident #93 was assessed by MD/Practitioner, orders received/implemented as indicated. Licensed Nurse #1 was provided individualized re-education including competency demonstration of tracheostomy care. Director of Nursing, ADON, and/or Unit Manager conducted a Quality Review of current facility residents with tracheostomies for care and services provided per standard. Follow up based on findings. Director of Nursing and contracted Respiratory Therapist provided re-education for Licensed Nurses regarding provision of tracheostomy care and services per standard including competency demonstration. The Director of Nursing will be	10/1/18

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F 684	Continued From page 4 at the front of the neck to create a direct airway) care. A progress note written by the Nurse Practitioner (NP) dated 08/08/18 read as: following closely due to recent diagnosis of pneumonia at end of July. The plan was for the nurses to monitor the patient for any changes in status and instructed to notify the physician of any of these changes. The care plan last reviewed on 08/21/18 identified the problem of respiratory risk due to an ineffective breathing pattern related to the tracheostomy. The goal included Resident #93 would have no signs or symptoms of aspiration pneumonia through the next review. The nursing approach was to monitor and report respiratory rate, depth and quality, monitor lung sounds, pulse oximetry (a measurement of oxygen levels in the blood) as ordered, monitor, and report temperature. During an observation on 09/04/18 at 2:23 PM, upon entering the room, Resident #93 expelled a moderate amount of a milk colored substance from the mouth. Resident #93 expelled the substance on two occasions, one after the other. A large amount covered a towel that was on the resident's chest. A family member raised the head of the bed from approximately a 45 degree angle to a 90 degree angle, removed the towel and cleaned the emesis, then called for staff assistance using the call light. Nurse #1 entered the resident's room and begun to provide suctioning outside the tracheostomy site. The family member checked her pocket book and located an oximeter (a device placed on the finger to measure oxygen levels in the blood). She placed the oximeter on the resident's finger,	F 684	responsible for implementing this plan of correction. The Director of Nursing introduced the plan of correction to and Ad Hoc QAPI Committee meeting on 9.19.2018. Director of Nursing/ADON/Unit Manager to complete Quality Improvement Monitoring of tracheostomy care and services provided per standard weekly x 4 weeks, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. QAPI committee consists of, but not limited to: Medical Director, Executive Director, Director of Nursing, and Assistant Director of Nursing, Activities Director, Social Services Director, Maintenance Director, Dietary manager, MDS nurse and direct care givers.	

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F 684	Continued From page 5	F 684		

which read 82%. Resident #93 was on room air during the observation and was observed coughing and gagging. Nurse #1 explained the oxygen level was low, she would get Resident #93 an oxygen tank, and she left the room. She returned with the oxygen tank and placed a mask over the tracheostomy site. Resident #93's oxygen level increased to 95% with oxygen in place. Milk colored secretions were observed in the canister of the suctioning equipment located at the bedside of Resident #93. Nurse #1 was not observed to collect a set vital signs or listen to the lung sounds of Resident #93.

Review of the nurse note dated 09/04/18 written by Nurse #1 read in part the resident had spit up a very small amount of tube feeding. She begun to cough and was suctioned at the tracheostomy site. She obtained a small amount of secretions at opening of the tracheostomy. Resident #93 became clammy with an oxygen level of 82%. Nurse #1 provided an oxygen tank and applied oxygen via mask, and the level increased to 95%. The documentation specified Resident #93 appeared less restless and was noted to be coughing less. The nurse wrote in her note she observed a decrease of respiratory problems.

Review of a nurse note dated 09/04/18 at 5:00 PM written by the Director of Nursing (DON) read in part, oxygen level at 92% on room air, lungs without abnormal sounds, or wheezing. Resident doesn't have any abnormal bronchial sounds. A cough was noted, and the resident was able to clear the secretions. The NP was notified of the incident and orders were obtained by the Unit Manager. No distress was noted.

During an interview on 09/05/18 at 11:54 AM, the

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DON explained she assessed Resident #93 after the surveyor informed her about the resident having a large amount of emesis on 09/04/18. She obtained a full set of vitals, listened to the lungs for abnormal sounds, and administered a breathing treatment. Resident #93 did improve after the breathing treatment and seemed more relaxed. The DON stated based on the note Nurse #1 documented on 09/04/18 she felt Nurse #1 was unaware of the actual amount of emesis produced. The DON added the Unit Manager notified the NP and received an order for a chest x-ray and to monitor vital signs.

During an interview on 09/05/18 at 2:32 PM, the Nurse Practitioner (NP) explained after being notified of the incident on 09/04/18, she asked the facility to obtain a chest x-ray due to Resident #93 being very high risk for aspiration. The NP had seen the resident twice this month and three to four times last month due to pneumonia. The NP revealed it was important she was notified of increased secretions and revealed Resident #93's aspiration risk was greater due to chronic changes in the lungs, the inability to deep breath, immobility, and multiple co-morbidities.

During an interview on 09/05/18 at 2:56 PM, the Unit Manager explained after being informed by the surveyor on 09/04/18 regarding the resident having a large amount of emesis, speaking to Nurse #1, and the history of Resident #93, she called the NP on 09/04/18. She also explained the DON assessed the lung sounds and obtained a set of vital signs on 09/04/18. She had received a physician's order for a chest x-ray and the NP would follow up in the morning.

During an interview on 09/05/18 at 3:08 PM,

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F 684	Continued From page 7	F 684		

Nurse #1 explained a Nurse Aide informed her Resident #93 had spit up and she should check on the resident. When she observed the resident, the resident was coughing. She could see the amount of secretions coming out of the tracheostomy site and used a suctioning device at the opening. After the family member checked the resident's oxygen level, the oximeter read 82% on room air. Nurse #1 explained she provided oxygen via mask and the level increased to 95% and the resident began to calm down. Nurse #1 explained she checked on the resident later who appeared better and gave report to the oncoming nurse who took over the care but did not report what had occurred to anyone else. Nurse #1 revealed she was somewhat familiar with Resident #93 and explained prevention of aspiration was: to have the head of the bed above the heart to prevent fluid getting into the lungs, after tube feeding keep the head of bed elevated and observe for signs of emesis and coughing, to check the mouth and nose for excess fluid, and remove if needed to maintain the airway. The nurse stated she didn't see lots of secretions and didn't feel the resident was in distress. Nurse #1 explained if she had seen a loss in the resident's level of consciousness or if the resident had abnormal vital signs she would notify the physician. She explained Resident #93 appeared calm and wasn't in distress.

During an additional interview on 09/07/18 at 8:19 AM, the NP explained she would like to be informed when an emesis episode occurred and expected the nurse to listen for abnormal lungs sounds and collect a set of vital signs to report to the Medical Doctor (MD)/NP. She revealed due to the resident's recent recovery from pneumonia

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F 684	Continued From page 8 and co-morbidities, she followed Resident #93 closely and wanted to know when there was a possibility of aspiration. She explained the resident had no control over swallowing and was a high risk for aspiration. During an additional interview on 09/07/18 02:52 PM the DON revealed it was her expectation the nurse would ask the family member who witnessed the emesis how much emesis the resident expelled and communicate the incident to her, the Unit Manager, or the MD/NP due to the resident's risk for aspiration and recent recovery from pneumonia. She expected the nurse would have collected a set of vital signs and listened for abnormal lung sounds.	F 684		
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	F 761		10/1/18

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F 761	Continued From page 9 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 observations, record review, and staff interviews the facility failed to remove 1 vial of expired Novolog FlexPen and 6 bottles of expired Over-the-counter (OTC) medications from 2 of 6 medication carts in the facility. Findings included: A review of the facility policy section 5.3 regarding Storage and Expiration of Medications, Biological, Syringes and Needles that was last updated on 07/28/14 indicated the facility should ensure that medications and biologicals had an expiration date on the label, had not been retained longer than recommended by the manufacturer or supplier guidelines and had not been contaminated or deteriorated. Once any medication or biological package was opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Review of the Package Insert for Novolog revealed once a FlexPen was being used, it should be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. A NovoLog FlexPen that was in use must not be stored in the refrigerator. 1. a. Resident #91 was admitted to the facility on	F 761	After performing an internal root-cause analysis, it was determined that there was not an effective system in place for ensuring the medication carts were routinely inspected for expired medications. Expired items removed from med carts at the time identified, currently medication stored within carts have current date. Director of Nursing and Unit Manager(s) have conducted a Quality Review of facility medication carts to ensure items stored are within current date. Follow up based on findings. Licensed Nurses provided re-education by the DON regarding medication cart inspection and the destruction of expired medications. The Director of Nursing will be responsible for implementing this plan of correction. The Director of Nursing introduced the plan of to an Ad Hoc QAPI committee meeting on 9.19.2018. Director of Nursing/ADON/Unit Managers(s) to complete Quality Improvement Monitoring of facility medication carts to ensure items stored within current date weekly x 8 weeks then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on	

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F 761	Continued From page 10 12/06/16 with diagnoses included diabetes mellitus (DM). Review of physician's order indicated Resident #91 had an order to receive Novolog FlexPen per sliding scale before meals and at bedtime subcutaneously four times daily related to type II DM. During a medication storage check conducted on 09/06/18 at 10:10 AM an Novolog FlexPen that was opened on 08/02/18 for Resident #91 was found in the medication cart for Upper C hall. Per Package Insert, this Novolog FlexPen should be discarded 28 days after it was opened and stored in the medication cart on 08/30/18. Review of Medication Administration Records (MAR) revealed Resident #91 was receiving Novolog FlexPen in the past 6 days. Further review indicated Resident #91's blood glucose levels were remained at the baseline for the past 1 week. Subsequent medication storage check revealed the following expired OTC medications were also found in the medication cart for Upper C hall: b. An opened bottle of 25 tablets of Simethicone 80 milligrams (mg) expired on 08/31/18. c. An opened bottle of 98 soft gels of Vitamin B Complex expired on 03/31/18. d. An opened bottle of 86 tablets of magnesium oxide 500 mg expired on 06/30/18. e. An opened bottle of 44 tablets of Eye-Vites (nutrition for eyes) expired on 04/30/18.	F 761	findings. QAPI committee consists of, but not limited to: Medical Director, Executive Director, Director of Nursing, and Assistant Director of Nursing, Activities Director, Social Services Director, Maintenance Director, Dietary manager, MDS nurse and direct care givers.	

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F 761	Continued From page 11	F 761		

f. An opened bottle of 87 tablets of Prenatal Multivitamin expired on 02/28/18.

During an interview on 09/06/18 at 10:18 AM Nurse #1 acknowledged that the above medications had expired and needed to be discarded. She stated the nurses were instructed to check the expiration of the medication before administration and to check their respective medication cart each shift to ensure proper storage and free of expired medication. She had been assigned to work at other halls recently and was not sure the nurses who worked at Upper C hall had checked the medication cart lately.

During an interview on 09/06/18 at 10:28 AM Nurse #2 who was also the Unit Manager stated the facility had a system in place to ensure proper medication storage and free of expired medication. Other than instructing the nurses to check each medication for expiration before administration, the third shift nurses were ordered to check their entire medication cart every shift. In addition, the Consultant Pharmacist would randomly check the medication storage rooms and carts when they visited the facility at least once monthly or as needed. She attributed the incident as a human error as it seemed that the medication cart for Upper C hall had been left out during the checking process.

During a subsequent medication storage check on 09/06/18 at 12:45 PM, 2 bottles of expired OTC medications were found in the medication cart for Bottom D hall:

g. An opened bottle of 15 tablets of Aspirin 325 mg expired on 11/30/17.

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F 761	Continued From page 12 h. An opened bottle of 9 tablets of Fioricet 50/325/40 mg expired on 08/30/18. Review of MAR revealed the bottle of Fioricet was for Resident #27 and it had not been used since 08/30/18. During an interview on 09/06/18 at 12:47 PM Nurse #4 acknowledged the above 2 bottles of OTC medications were expired and should be discarded. She checked the entire medication cart when she worked at night shift. She had been working mostly in the day shift recently with less down times. She checked the medication cart whenever she had time and mostly just checking those frequently used medications. During an interview on 09/06/18 at 01:01 PM the Director of Nursing (DON) stated all the above medications were expired and needed to be discarded. She added the Consultant Pharmacist was in the facility last week to check all the medication carts and storage rooms. Despite there was a system in place to ensure proper medication storage and free of expired medication, the DON further stated that some of the nursing staff had not been fully executing the order to check their respective medication cart thoroughly in third shift as instructed. It was her expectation for the facility to store all medication properly according to manufacturer's guidelines and free of expired medications.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides-	F 806		10/1/18

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F 806	Continued From page 13 §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and resident interviews the facility failed to honor food preferences for 3 of 3 residents reviewed for food preferences (Residents #30, Resident #53, and Resident #68). Findings included: 1. Resident #68 revealed she was admitted to the facility 01/18/17 with diagnoses including diabetes, anxiety, and Alzheimer's disease. The quarterly Minimum Data Set (MDS) dated 07/30/18 revealed Resident #68 was severely cognitively impaired and was independent with eating. Review of Resident #68's nutrition care plan last updated 08/13/18 revealed she was to receive soft food items. Review of Resident #68's diet order revealed she was to receive a pureed diet with fortified foods. Observation of Resident #68 on 09/06/18 at 8:06 AM revealed she was in her room and had her breakfast tray in front of her. Review of the tray card that was on the resident's meal tray revealed she was to receive a fortified pudding parfait.	F 806	After performing an internal root-cause analysis, it was determined that there was not an effective system in place for ensuring the resident preferences and tray cards were accurate. Residents #30, 53 and 68 meal preferences are currently being honored. Food Services Manager conducted a Quality Review of resident tray cards/trays to ensure preferences being honored. Follow up based on findings. The District Food Services Manager provided re-education for Dietary Staff on 9.20.2018 and focused on the importance of honoring resident preferences and tray card accuracy during mealtime. The Food Services Manager will be responsible for implementing this plan of correction. The Director of Nursing introduced the plan of correction to an Ad Hoc QAPI committee meeting on 9.19.2018. Food Services Manager/Designee to conduct Quality Improvement Monitoring of resident tray cards/trays utilizing a sample of 5 to ensure preferences honored 5x/week x 2 weeks, weekly x 4 weeks, then monthly and as needed. Findings to be reviewed at monthly QAPI Committee Meeting.	

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F 806	Continued From page 14 Observation of Resident #68's tray revealed there was no fortified pudding parfait on her tray. An interview with the dietary manager on 09/06/18 at 8:49 AM revealed Resident #68 should have received a fortified pudding parfait if her tray card stated she should have received a fortified pudding parfait. An interview with the Administrator on 09/06/18 at 5:35 Pm revealed she expected the tray cards to be as accurate as possible and she expects residents' preferences to be honored. 2. Resident #30 was admitted to the facility 04/17/15 with diagnoses including hypertension (high blood pressure), dementia, and respiratory failure. Review of the quarterly Minimum Data Set (MDS) dated 07/16/18 revealed Resident #30 was moderately impaired for cognition and was independent with eating. Review of Resident #30's care plan for nutrition last updated 07/30/18 revealed the facility was to provide his food preferences. Review of Resident #30's current diet order revealed he was to receive a regular diet. Observation of Resident #30 on 09/04/18 at 12:26 PM revealed he was in the dining room and had his lunch meal in front of him and was eating his meal. Review of the tray card that was with the resident's meal revealed he was supposed to receive a tomato sandwich with meals. Observation of Resident #30's meal revealed there was no tomato sandwich with his meal.	F 806	Monitoring schedule modified based on findings. QAPI committee consists of, but not limited to: Medical Director, Executive Director, Director of Nursing, and Assistant Director of Nursing, Activities Director, Social Services Director, Maintenance Director, Dietary manager, MDS nurse and direct care givers.	

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F 806	Continued From page 15	F 806		

An interview with Resident #30 on 09/04/18 at 12:26 PM revealed he did not get a tomato sandwich with his meal.

Observation of Resident #30 on 09/06/18 at 1:20 PM revealed he was in his room with his lunch meal tray in front of him. Review of the tray card that was on the resident's meal tray revealed he was supposed to receive a tomato sandwich with meals. Observation of Resident #30's meal tray revealed there was no tomato sandwich on his meal tray.

An interview with Resident #30 on 09/06/18 at 1:20 PM revealed he wanted a tomato sandwich on his meal tray and did not get a tomato sandwich. Resident #30 said he had requested to receive a tomato sandwich with his lunch meal but only received it a couple of days a week.

An interview on 09/06/18 at 1:32 PM with the acting dietary district manager revealed if a meal tray card stated a resident was to receive a tomato sandwich the resident should have received a tomato sandwich.

An interview with the Administrator on 09/06/18 at 5:35 Pm revealed she expected the tray cards to be as accurate as possible and she expects residents' preferences to be honored.

3. Resident #53 was admitted to the facility 02/01/17 with diagnoses including anemia, depression, diabetes, and chronic kidney disease.

Review of the quarterly Minimum Data Set (MDS) dated 07/20/18 revealed Resident #53 was

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F 806	Continued From page 16	F 806		

cognitively intact and was independent with eating.

Review of Resident #53's care plan for nutrition last updated 08/03/18 revealed the facility was to provide his food preferences.

Review of Resident #53's diet order revealed he was to receive a carbohydrate controlled diet.

Observation of Resident #53 on 09/06/18 at 8:24 AM revealed he was in his room eating his breakfast meal. Review of the tray card that came on the resident's meal tray revealed he was not to receive sausage. Observation of Resident #53's meal tray revealed he received sausage on his tray.

An interview with Resident #53 on 09/06/18 at 8:24 AM revealed he wanted bacon instead of sausage.

An interview with the acting dietary district manager on 09/06/18 at 8:35 AM revealed if a tray card stated no sausage the resident should not have received sausage.

Observation of Resident #53's tray card on 09/06/18 at 1:17 PM revealed he was to receive egg salad on his tray. Observation of Resident #53's meal tray revealed there was no egg salad on his meal tray.

An interview with Resident #53 on 09/06/18 at 1:17 PM revealed he did not get egg salad on his tray and he wanted egg salad.
An interview with the acting dietary district manager on 09/06/18 at 1:32 PM revealed if a tray card stated a resident was to receive egg

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F 806	Continued From page 17 salad the resident should have received egg salad. An interview with the Administrator on 09/06/18 at 5:35 PM revealed she expected the tray cards to be as accurate as possible and she expects residents' preferences to be honored.	F 806		