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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	**2059 TORREDGE ROAD DURHAM, NC 27712**

(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
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the	E 037		3/13/20

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

Electronically Signed | 03/06/2020

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procedures necessary to protect patients and others.

(v) Maintain documentation of all emergency preparedness training.

(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training every 2 years.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of all emergency

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E 037	Continued From page 2	E 037		

preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected

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E 037	Continued From page 3 roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide and maintain documentation of annual staff training on the facility emergency preparedness plan. The findings included: During a review of the facility ' s emergency preparedness plan with the Administrator on 2/13/20 at 4:07 PM, there was no documentation that staff received annual training of the emergency preparedness plan. The Administrator stated that all new hires are given the training on hire. She stated the training documentation might have been put in the Quality Assurance binder.	E 037	E307 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. No residents were found to be by the lack of documentation of annual staff training on the facility emergency preparedness	

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E 037	Continued From page 4 The Administrator returned to the surveyor documentation on 5 fire drills that were conducted in March, April, May, August and September of 2019. No documentation of emergency preparedness training was provided.	E 037	plan. Any resident living in the facility has the potential to be affected by the lack of documentation of annual staff training on the emergency preparedness plan. The facility staff were in-serviced by the Maintenance Director on 3/10-3/11/20 regarding the facility emergency preparedness plan. The facility emergency preparedness plan has been added to the facility orientation agenda and to the annual mandatory education calendar. No employee will be allowed to work will be allowed to work without documentation of the required training. Completion of the emergency preparedness training will be tracked by the Staff Development Coordinator ongoing, to ensure all employees receive the training in orientation and annually. Compliance will be reported to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 2/10/20 through 2/14/20. 9 of the 35 complaint allegations were substantiated with deficiencies at F558, F585, F684, F689, F755 and F759. Event ID #T6CO11.	F 000		
F 558	Reasonable Accommodations Needs/Preferences	F 558		3/13/20

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F 558 SS=D	Continued From page 5 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to place a resident ' s call light within reach to allow for the resident to request staff assistance if needed for 1 of 1 resident (Resident #108) reviewed for accommodation of needs. The findings included: Resident #108 was admitted to the facility on 8/15/18 with re-entry from a hospital on 4/10/19. Her cumulative diagnoses included non-Alzheimer ' s dementia, multiple myeloma (a cancer that forms in a type of white blood cell called a plasma cell), aphasia (loss of the ability to understand or express speech) following a cerebral infarction (stroke), and a history of falls. A review of Resident #108 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 1/21/20 indicated Resident #108 had severely impaired cognitive skills for daily decision making. Section B of the MDS revealed the resident had unclear speech but was usually able to make herself understood, and she had clear comprehension and the ability to understand others. The resident required supervision for eating; extensive assistance with bed mobility, dressing, toileting, and personal	F 558	F558 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The call light for resident #108 was placed within reach of the resident on 2/11/20. It was placed within reach again on 2/13/20 after the staff was notified that it was not within reach. NA #3 was educated by the Director of Nursing (DON) on 2/13/20 regarding the importance of keeping the call light in reach for all residents. All residents have the potential to be affected. Rounds were completed by the Administrative Nursing Team on 2/13/20 after being notified there was a call light that was not within reach. No other call lights were identified as not being within reach during those rounds.	

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F 558	Continued From page 6 hygiene; and was totally dependent on staff for transfers. Section H of the MDS assessment indicated Resident #108 was always incontinent of bowel and bladder. Resident #108 ' s comprehensive care plan included the following areas of focus, in part: --The resident has a history of falls with no injury. The planned interventions included the resident using her call light to call for assistance before ambulating (initiated 1/14/19); and, --The resident has an Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance / strength, impaired balance, and cognition deficits. The planned interventions included encouraging the resident to use her call light to call for assistance (initiated 8/24/18). An observation was conducted of Resident #108 on 2/11/20 at 7:50 AM as she was sitting in a Broda chair on the left side of her bed. Her call light button was observed to be wound around the right railing of her bed (opposite side of the bed and not within reach of the resident). An interview was conducted on 2/11/20 at 8:50 AM with Nursing Assistant (NA) #3. NA #3 was the 1st shift nursing assistant assigned to care for Resident #108. During the interview, NA #3 was asked if Resident #108 was able to use her call light to request staff assistance, if needed. The NA stated the resident was able to use the call light and reported she would use it both when she was in bed and in her wheelchair in the room. When asked what the resident typically needed when she used the call light, NA stated it varied but sometimes she was just asking for something to drink.	F 558	The facility staff were in-serviced by the Administrator and the DON on 3/6-3/11/20 regarding the importance of ensuring call lights are in reach of the residents and that it is the responsibility of all staff to check for call light placement with every encounter with the residents when they are in their rooms. Department heads were educated on 2/19/20 regarding checking for call light placement during their Angel Rounds. Call light placement has been added to the Angel Rounds Checklist to be completed three times weekly. Call light placement audits will be completed by the Administrative Nursing Team or designee on at least five residents per hallway, at least three times weekly on various shifts, including weekends to ensure that call lights remain within reach. The audits will be completed until 100% compliance is maintained for at least two consecutive months. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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An observation was conducted and an interview attempted on 2/11/19 at 9:00 AM with Resident #108. The resident continued to be sitting in a Broda chair on the left side of the bed in her room. A bedside table had been placed in front of her for her breakfast meal. When asked, the resident stated she had eaten breakfast and reported it was good. The resident was then asked how she would let staff know if she needed assistance with something. When that question was asked, the resident started to feel around on her bed covers on the left side of her bed and appeared to be looking for the call light. The resident was asked if she was looking for the call light button. She stated she was but indicated she did not need anything at that time. Resident #108 ' s call light was still located on the right side of the bed and out of reach for this resident.

An observation conducted on 2/11/20 at 9:50 AM revealed the resident's call light had been moved and placed on her bed covers closer to where she was sitting in the Broda chair. The call light was now within reach of Resident #108.

On 2/12/20 at 3:20 PM, Resident #108 was observed to have pushed her call light button. A brief interview was conducted with the resident on 2/12/20 at 3:21 PM. During the interview, the resident reported she needed to use the bathroom. A continuous observation was conducted and revealed Resident #108 ' s call light was answered by a staff member on 2/12/20 at 3:25 PM and she was assisted with her needs.

On 2/13/20 at 2:39 PM, Resident #108 was observed to be lying in her bed as she waved for someone to enter her room from the hallway. Upon entering, the resident stated she needed a

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nurse to come help her. The resident ' s call light was observed to be on the floor underneath the resident's bed and out of her reach. Upon exiting the room, Housekeeping Staff Member #1 came out of the room adjacent to Resident #108 ' s and reported the resident had requested a nurse come help her.

Accompanied by Nurse #4 to Resident #108 ' s room on 2/13/20 at 2:40 PM, an observation was again made of the call light located under her bed. When questioned, the resident told the nurse she wanted the bathroom door closed. Before leaving the room, Nurse #4 clipped the call light onto Resident #108 ' s bed linens and within the resident ' s reach.

An interview was conducted on 2/13/20 at 2:47 PM with Nurse #4. During the interview, the nurse confirmed Resident #108 could use her call light. Nurse #4 reported she thought the resident was uncomfortable with a male housekeeper cleaning the bathroom shared with the adjacent room and that's why she wanted the door closed. When asked, the nurse stated sometimes Resident #108 would use the call light and forget what she was wanting when it was answered. However, she noted sometimes the resident was able to request something in particular when she rang for assistance. Nurse #4 stated when talking with the resident, "You just have to be patient."

An interview was conducted on 2/14/20 at 1:00 PM with the facility ' s Director of Nursing (DON). During the interview, observations of the placement of Resident #108 ' s call light were discussed. The DON reported she would want her nursing staff to ensure the call light was

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F 558	Continued From page 9 always within reach for a resident such as Resident #108.	F 558		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information	F 585		3/13/20

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of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a

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F 585	Continued From page 11 summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of resident council meeting minutes, the facility failed to address and resolve ongoing grievances about food that were reported at resident council meetings for 7 of 7 residents who were reviewed for grievances (Resident #3, #26, #28, #31, #51, #84 and #112). The findings included: The resident council minutes dated 11/6/19 documented resident concerns about food including: cold temperatures; food was being served late; aides needed to pass trays in a timely manner; resident wanted to know if they could have shelled eggs; no silverware in the dining room; and the milk supply was always running out. Resident council minute concerns on 12/4/19 included no documentation on how the	F 585	F585 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. A Resident Council Meeting that included the Dietary Manager, Director of Nursing, and specifically residents #3, #26, #28, #31, #51, #84, and #112 was held on 3/6/20 regarding their dietary issues and to address what steps will be taken to resolve their concerns. A group grievance	

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F 585	Continued From page 12 concerns from 11/6/19 were addressed. Resident council minutes dated 1/8/20 documented concerns that likes/dislikes were mixed up, open foods being served (cakes/breads) on tray, foods being too hot due to seasoning and bread too soggy. Residents not receiving lactose free milk and grits are not all the way done. Another resident reported scramble eggs were cold when he received them. Residents of the group suggested getting new trays. Resident council minutes dated 1/31/20 documented concerns that food was too spicy, and food not being covered when brought to the halls, likes/dislikes are not being reviewed closely, food menus doesn't match with the meal. An interview with the members of the Resident Council was conducted on 02/12/20 at 2:14 PM. A total of 7 residents, who regularly attended the facility ' s monthly resident council meeting were present at this meeting. The meeting revealed all seven residents present had ongoing concerns with foods being served cold, meal delivery , foods served with sugar, food quality and the same meal selection week after week for the past 3 months. Multiple residents reported once the meal carts were delivered to the halls, the food would sit in the cart for a long period of time, resulting in the food being served cold for all three meals. In addition, the members of the group reported administration and previous dietary manager stated they would resolve the concerns, but they were unaware of what action was taken to resolve the issue. The food continued to come cold and there were no changes in the quality or selection of food	F 585	form was initiated to document the concerns and provide documentation of steps taken to resolve/address concerns. The Dietary Manager conducted interviews 2/17/20 to 2/28/20 with all interviewable residents to determine preferences and if there were any dietary concerns that needed to be addressed. A grievance form was initiated to document the concerns and provide documentation of steps taken to resolve/address concerns. Resident Council minutes for the last 90 days will be reviewed by the Administrator to determine if there were any grievances, if the grievance was resolved, and that notification has been made with the individual that initiated the grievance. The Department Heads (including the Activities Director) were in-serviced by the Director of Nursing on 2/19/20 regarding the Grievance process and the regulation regarding written notification of the person who initiated the Grievance of outcome before closing the Grievance. Grievances will be reviewed at the morning Stand up meeting to ensure timely reporting and follow up. The Administrator will ensure that contact has been made with the individuals who initiated the Grievance before the grievance can be closed and or resolved. The Grievance Log will be reviewed and discussed during the steering QAPI committee monthly. The steering committee will direct further analysis and	

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F 585	Continued From page 13 choices. Food alternates were not posted therefore, resident unable to make food selection. Food preferences not being updated or honored. No fresh fruit available or offered, meats were dry and tough, vegetables, mushy/overcooked, snacks were not being delivered consistently or offered. Cold food due to staff letting food sit on the hall. The residents also reported they received the same meal two to three times a week. Individual interviews with residents, who attend the resident council interview on 1/08/20, and were identified as alert and oriented revealed the following: During an interview on 2/12/20 at 2:14PM, Resident #3 stated he was unaware of the meal alternate for the day, meats were dry/tough. Resident #3 stated he ended up throwing a lot of food away. The vegetables were soggy with no flavor, the food came cold because they reheat it up to get it warmed up again, "I end up eating what is served because it would take too long to get the meal back." Resident #3 reported that he would not eat a lot of the meals because they would serve the same meal several times a week and over bake things and vegetables often were mushy and overcooked. During an interview on 2/12/20 at 2: 16 PM, Resident #26 stated she received foods that were on her dislike list, meats were dry/tough and difficulty to chew. Resident #26 reported she was unable to find out the alternate in advance because it was not posted and would receive the same meal for lunch and dinner. During an interview on 2/12/20 at 2:18 PM,	F 585	interventions based on reported outcomes and direct further investigations.	

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Resident #28 stated the vegetables were overcooked/mushy and uneatable at times. Meats were dry/tough and difficult to cut. Resident #28 reported they don ' t ever see any alternate menu posted. "We have been told they had to follow the corporate menus and could not be changed or add any other food items like fresh fruit, sandwich, so we either eat or throw it away."

During an interview on 2/12/20 at 2:20 PM, Resident #31 stated the food selection was the same week after week. Resident #31 further stated the DM had not discussed her food preferences and likes/dislikes. The meal today was lukewarm. Resident #31 stated the residents shouldn't have to keep asking staff to reheat the food when it should have come hot when it leaves the kitchen.

During an interview on 2/12/20 at 2:25, PM, Resident #51 stated her preferences were not updated, received food on dislike list, received same meal two to three times a week, no fresh fruit was offered, and no sandwiches offered for diabetic residents. The food was often served cold due staff leaving the trays on the hall, talking and not delivering trays when they come out.

During an interview on 2/12/20 at 2:30 PM, Resident #84 stated she reported in a meeting about the food being served sweet, cold and no changes in the meal selection two months ago. Resident #84 further stated the food selection process had not changed, foods continued to be served sweet and cold. Resident #84 reported no one from dietary or administration had spoken with her about her likes/dislikes/preferences or changes in the dietary process. Resident #84 indicated they told us there would be some

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changes, but it had not occurred at this time.

During an interview on 2/12/20 at 2: 35 PM, Resident #112 stated food preferences were not honored, received food from dislikes, no alternate meal posted therefore cannot select alternate meal. Staff had to run around to find out what was the alternate. Resident #112 reported she received same meal items several times a week, the food was too cold, and it sat on hall to long before being delivered. Some of the foods were two spicy. Resident #112 further stated "we pay for the food and we are not getting quality food, there is no reason we go meeting after meeting discussing food concerns and the meals come the same." "I get tired of sending my food back trying to find out the alternate only to find out I don't like the alternate either. We should not have to ask our family to bring different foods because what they are serving was not eatable."

Interview on 2/13/20 at 8:36 AM, the Activities Assistant stated food concerns had been an on-going issue depending on who the new administration and/or dietary manager was at the time. On-going concerns have included the quality of the food. Examples included foods being over/under cooked, cold food/delivery of tray in a timely manner, food selection may be limited or not available, food preferences likes/dislikes not being honored and menu choices not being honor. Residents reported there had been some improvements for short periods of time and then the quality of food returns to what residents described. The grievance concerns would be brought to the attention of the department heads in the morning meeting. The department heads would address the concerns with the residents in the group.

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Since there had been a lot of staff changes in the kitchen some things get resolved or improved, while others continue to be a problem. The Activity Assistant stated she had reported these repeated food concerns at the morning meeting.

Interview on 2/13/20 at 11:15 AM with the Regional Dietician stated he began employment 2 weeks ago and became aware of many dietary concerns that included food temperatures, lack of food/menu variety , no alternate menus available for residents, meats served dry/tough, vegetables served overcooked/ mushy, snacks not being available for residents with diabetes or consistently being served. Residents ' preferences not being honored. He confirmed the new dietary manager had not yet been to the resident council.

Interview on 2/12/20 at 3:20 PM, the Director of Nursing stated group concerns should be brought to the attention of the department heads in the standup meeting. The department head would be responsible for responding and resolving the concerns individually as well as the group within 5 days. The group concerns would be discussed within the next month or sooner depending upon the concern. The grievance should be documented with a resolution to the concern and discussed with the individual and/or group. The DON and administrator would follow-up with the resident council and/or individual. The DON acknowledge she was aware of the residents ' food concerns.

Interview on 2/13/20 at 10:00 AM, the Administrator stated she recently attended a resident council meeting and numerous concerns regarding dietary was brought to her attention.

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F 585	Continued From page 17 The Administrator stated the management team would be meeting to review group grievances and develop a plan of action to the identified concern. The dietary team would be meeting with the residents and updating preferences, updating/reviewing menus and snack/food options.	F 585		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of: 1) Dialysis for 1 of 2 residents (Resident #58) reviewed who received dialysis; and 2) Medications for 1 of 5 residents (Resident #83) reviewed for unnecessary medications. The findings included: 1) Resident #58 was admitted to the facility on 10/5/18 with re-entry on 1/3/20. His cumulative diagnoses included chronic renal failure requiring hemodialysis. Resident #58 ' s most recent quarterly Minimum Data Set (MDS) assessment dated 1/3/20 was reviewed. Section O of the MDS indicated the resident did not receive dialysis. An interview was conducted on 2/12/20 at 3:45 PM with the facility ' s MDS Coordinator. During the interview, the MDS Coordinator reviewed	F 641	F641 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. A modification of the quarterly MDS for resident #58 dated 2/13/20 to include the coding for dialysis to the special treatments and procedures section was completed by the Director of Nursing on 2/14/20. A modification of the quarterly MDS for resident #83 dated 3/6/20 to include the coding for the antipsychotic to the medication section was completed by the Clinical Reimbursement Director	3/13/20

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F 641	Continued From page 18 Resident #58's 1/3/20 quarterly MDS assessment. She confirmed Section O of his MDS did not indicate he received dialysis. The MDS Coordinator reported she would review the resident ' s medical record in more detail to determine whether or not the assessment had been coded correctly. A follow-up interview was conducted on 2/13/20 at 8:20 AM with the MDS Coordinator. At that time, the MDS Coordinator reported a review of Resident #58 ' s medical record revealed he did receive dialysis while he was a resident during the 7-day look back period (for the quarterly MDS dated 1/3/20). She stated the MDS assessment was coded to indicate Resident #58 did not receive dialysis at the time the assessment was completed because there was no documentation in his medical record to indicate he had. The Coordinator reported his dialysis record was scanned into the electronic medical record after the MDS was completed. When asked how the MDS should have been coded, the MDS Coordinator stated it should have indicated Resident #58 received dialysis while a resident. She stated an MDS modification/correction would need to be completed and submitted to indicate this. An interview was conducted on 2/13/20 at 8:30 AM with the facility ' s Director of Nursing (DON). During the interview, the coding of Resident #58's MDS was discussed. The DON stated MDS coding issues were identified as a concern during a recent mock survey. Upon further inquiry, the DON reported she would expect it (dialysis) to have been coded correctly on the resident ' s MDS assessment.	F 641	(CRD). An audit of special treatments and procedures and medications of all MDSs completed in the last 60 days was completed by the CRD on 3/6/20 to 3/11/20 to ensure the MDSs correctly reflected special treatments and procedures and medication status. If the MDS did not correctly reflect special treatments and procedures status and medications, a modification assessment was completed and submitted to remain in compliance with the Resident Assessment Instrument (RAI) Manual. The Clinical Reimbursement Director (CRD) and the Clinical Reimbursement Staff (CRS) were in-serviced by the Director of Nursing on 2/14/20 regarding accurately coding of the MDS. The special treatments and procedures and medications of MDSs in progress will be reviewed the Interdisciplinary Team in the Daily Clinical Meeting prior to the Assessment Reference Date (ARD) to ensure the special treatments and procedures and medications are accurately reflected on the MDS. The accuracy of the special treatments and procedures and medications of 10% of MDSs completed, will be audited by the CRD for the next two months, or until 100% compliance is achieved for two consecutive months, to ensure the MDSs are accurately coded. Outcomes of those audits will be	

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F 641	Continued From page 19 2) Resident #83 was admitted to the facility on 8/12/19 with diagnoses of, in part, bipolar disorder. A review of a quarterly MDS assessment dated 1/13/20 revealed Resident #83 did not receive an antipsychotic medication. A review of the January 2020 physician orders revealed an active order for Seroquel 25 milligrams daily by mouth ordered 12/5/19. A review of the January 2020 Medication Administration Record for Resident #83 revealed Seroquel 25 milligrams by mouth was documented as administered on January 7th, 8th, 9th, 10th, 11th, 12th and 13th, all seven days of the look back period. An interview was conducted with MDS Nurse #1 on 2/12/20 at 10:11 AM. She stated when she collected the data for Resident #83 ' s assessment, she reviewed the physician orders and saw that he received Quetiapine (Seroquel) for depression and missed coding it as an antipsychotic.	F 641	presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	
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.	F 684		3/13/20

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F 684	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review the facility failed to keep the cholecystostomy (gallbladder catheter) drainage bag below the catheter to maintain bile drainage, for 1 of 1 resident, reviewed for cholecystostomy catheter care (Resident #220). Findings included: Resident #220 was admitted on 2/5/20. Review of the hospital discharge records dated 2/05/20, revealed while in the hospital Resident #220 received percutaneous cholecystostomy tube incretion (surgical treatment for gallbladder inflammation). She was discharged to the nursing home with the gallbladder catheter, connected to the drainage bag. Review of physician ' s order for Resident #220, dated 2/5/20, revealed the order to clean cholecystostomy post-surgical site with normal saline apply drain sponge every day shift; flush percutaneous cholecystostomy tube every eight hours with 10 ml (milliliter) of normal saline every shift; monitor drainage output for cholecystostomy tube every shift. Resident 220 ' s baseline care plan, dated 2/5/20, reflected her diagnoses, including cholecystostomy status, with initial goals and interventions, included catheter care for gallbladder catheter per physician ' s order. Review of Resident #220 ' s 5-day Minimum Data Set assessment, dated 2/12/20, revealed she was cognitively intact. Resident ' s diagnoses	F 684	F684 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. The cholecystostostomy drainage bag was removed from around the Resident #220's neck on 2/10/20 by the nurse upon notification by the surveyor regarding placement of the bag. Resident #220 has a BIMs score of 14 and was educated by the licensed nurse on 2/12/20 regarding safety and proper placement of the cholecystostostomy drainage bag. Any resident with a drainage tube/bag has the potential to be affected. An audit of all residents with drainage tubes was conducted on 2/13/20 by the DON to ensure all drainage tubes/bags were positioned properly to facilitate draining. The nursing staff was in-serviced on 3/7-3/11/20 by the DON or designee regarding proper placement of drainage tubes/bag and the importance of ensuring they are properly placed. Placement of drainage tubes/bags has been added to	

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F 684	Continued From page 21 included acute cholecystitis (gallbladder inflammation) without obstruction. Record review of the nurses ' notes, dated 2/6/20, Resident #220 received cholecystostomy catheter care and dark in color output from cholecystostomy tube was 50 ml. On 2/10/20 at 11:50 AM, during an observation/interview, Resident #220 was sitting in wheelchair in her room. She had the cholecystostomy drainage bag with cover, which was hanging around her neck at the level of her upper chest. The cholecystostomy catheter was connected to the drainage bag, collected small amount of bile. Resident #220 stated she could not recall who placed the drainage bag in upper chest position. On 2/10/20 at 1:40 PM, during an observation, Resident #220 was in bed. She had her cholecystostomy drainage bag on her chest, with the cover, which was hanging around resident ' s neck. The cholecystostomy catheter was connected to the drainage bag, which was one-third full of bile. On 2/10/20 at 4:05 PM, during an observation, Resident #220 was in wheelchair. She had the cholecystostomy drainage bag with cover, which was hanging around her neck on the level of her upper chest. The cholecystostomy catheter was connected to the drainage bag, half full of bile. On 2/10/20 at 4:10 PM, during an interview, Nurse #1 indicated that she was aware Resident #220 had the cholecystostomy with drainage bag. Nurse #1 knew that the drainage bag needed to be below catheter level for easy drainage, but she	F 684	the nursing rounds checklist for administrative nurses to be checking placement of the drainage tubes/bags. The Administrative Nursing Team or deisgnee will audit all residents with drainage tubes/bags at least twice weekly on various shifts to ensure drainage tubes/bags are properly placed until 100% compliance is maintained for at least two consecutive months. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 684	Continued From page 22 did not check the position of resident ' s drainage bag. On 2/14/20 at 12:05 PM, during an interview, Director of Nursing indicated that nurses on the floor were responsible to monitor the catheter and drainage bag position every shift to promote fluid drainage by gravity.	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews, the facility failed to prevent a resident, who was evaluated as an unsafe smoker, from possessing cigarettes and lighter while unsupervised for 1 of 1 resident (Resident #10) reviewed for safe smoking. The findings included: A review of the facility ' s policy titled "Smoking" updated on 4/23/19 revealed, in part, "all smoking materials will be stored by staff". Resident #10 was admitted to the facility on 8/17/19 with diagnoses of schizophrenia, anxiety and dementia.	F 689	F689 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. Nurse #13 was in-serviced by the DON on 2/11/20 regarding the facility smoking policy and not giving supervised smokers their cigarette until they were in the	3/13/20

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F 689	Continued From page 23 A review of a quarterly Minimum Data Set assessment dated 1/27/20 revealed Resident #10 was cognitively intact. Verbal behaviors occurred 1-3 days of the look back period. Resident #10 required extensive assistance with his activities of daily living. Resident #10 had no functional limitation in range of motion to his upper extremities. A review of the care plan revealed Resident #10 was an unsafe smoker as evidenced by a safe smoking evaluation. The goal was for the resident to smoke safely with supervision through the review date. Interventions included supervision at all times when smoking, review smoking policy with resident and provide protective equipment. A record review revealed a safe smoking evaluation, completed on 9/6/19, indicated Resident #10 was an unsafe smoker and required supervision when smoking due to being unable to light a cigarette and smoke, unable to demonstrate safe techniques and unable to remain alert during smoking. A nurse ' s note, authored by Nurse #3, dated 9/7/19 at 6:20 PM, revealed Nurse #3 was informed by a nursing assistant that Resident #10 was in the smoking area with a lighter. Resident #10 was observed lighting the lighter and putting it to his skin. Resident #10 was upset that he did not have any cigarettes. The nurse asked Resident #10 to turn over the lighter, he refused and stated, "you are not going to get my lighter". The nurse tried to redirect the resident and he became more and more agitated, bucking backwards in his wheelchair and flailing his arms. The resident calmed down when a nursing	F 689	smoking area with supervision and with protective equipment. Resident # 10 is now supervised at all times with smoking paraphernalia. Any resident that smokes has the potential to be affected. A meeting was held with all residents who smoke on 1/17/20 to review the smoking policy and sign/re-sign smoking agreements. The smoking policy is being followed by residents and staff at this time. The facility staff was in-serviced by the DON on 3/7-3/11/20 regarding the facility smoking policy and the importance of not giving supervised smokers their cigarette until they were in the smoking area with supervision and with protective equipment. This has been added to the facility orientation of facility and agency staff. A letter was drafted by the Administrator and sent to families regarding not giving cigarettes or lighters directly to their loved ones, give it to nursing staff for securement on 3/6/20. A sign was posted to inform visitors to the facility regarding the smoking policy and requesting they not give any smoking paraphernalia to any residents or light cigarettes for any resident. Random searches will be completed on resident #10’s person and room weekly until this resident is discharged to ensure the resident is not keeping any smoking paraphernalia. The smoking area will be audited at least ten times weekly on various shifts until	

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F 689	Continued From page 24 assistant offered him a cigarette and the lighter was retrieved. An interview was conducted with Nurse #3 on 2/11/20 at 11:45 AM. The nurse stated she was not assigned to Resident #10 that day and was walking through the courtyard and saw he had a lighter. She stated she observed Resident #10 lighting the lighter and placing the flame to his opposite hand. She asked the resident to turn over the lighter, but he refused and became combative. She stated he finally calmed down and gave the lighter to the nursing staff. She stated she did not know where he got the lighter from and he did not tell her. A nurse ' s note dated 9/7/19 at 10:59 PM revealed "resident noted to have a lighter and trying to go outside and smoke by himself. Staff attempted to redirect resident and get him to give the lighter to staff. After several attempts of redirecting, the resident gave nursing staff the lighter. A nurse ' s note dated 1/28/2020 at 02:39 AM revealed, "Resident requested cigarette and assistance putting on jacket, at this time I noted resident had a lighter hidden in his hand, so I confiscated the lighter and counselled him about this behavior and resident was allowed to smoke with my supervision." An observation was conducted on 2/10/20 at 12:31 PM of Resident #10 in the designated smoking area. The nursing assistant assisted the resident with the vest and supervised the resident while he smoked. The resident was able to smoke the cigarette without difficulty. The smoking area had an ash tray and place to discard the cigarettes. The resident did not have any lighter or cigarettes on him.	F 689	100% compliance is maintained for two consecutive months to ensure residents and staff are adhering the facility smoking policy. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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An observation on 2/11/19 at 9:00 AM revealed Resident #10 outside in the smoking area with a cigarette in front of him on the table. Resident #10 stated the nurse gave them to him. The observation continued until 9:13 AM when the Activity Assistant approached the entryway to the smoking area and stated she was waiting for the storage box with the cigarettes and lighters from the unit manager. The Activity Assistant stated she was responsible for taking the residents out to smoke during the day shift (7am -3pm) and there was a schedule they followed, 9:00 AM, 1:00 PM, 5:00 PM, 9:00 PM, 1:00 AM. She stated the residents were not allowed to keep their cigarettes and lighters on them.

An interview was conducted on 2/11/20 at 9:16 AM with Nurse #13. She stated she gave Resident #10 the cigarette pack from the med cart at 9:00 AM that morning, he removed 2 cigarettes and gave her the pack back. She did not give him his lighter. She stated she knew the it was near the smoking time and that staff went out with him to smoke.

An interview was conducted on 2/11/20 at 9:20 AM with the Unit Manager. She stated the residents ' cigarettes and lighters were kept in a box in the medication room She stated the activities staff were responsible for taking the residents out during the day shift, the unit manager takes over at 3 pm and the night shift nurse is responsible during the 11-7 shift. She stated the residents should not have cigarettes or lighters on their person. The surveyor requested to observe the storage box and it was noted Resident #10 ' s cigarettes were not in the box. The Unit Manager stated his cigarettes may be on the medication cart because the night shift

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F 689	Continued From page 26 nurse gives them to him at night and sometimes he goes out more frequently than the scheduled times. An interview was conducted on 2/11/20 at 9:31 AM with the Director of Nursing. She stated Resident #10 knew the smoking schedule and did not keep his cigarettes on him, however if someone did give him a cigarette, they didn ' t give him a lighter. She did not know where he got lighters from. She stated his cigarettes are kept in the medication cart because he smokes more frequently than the other residents.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		3/13/20

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F 692	Continued From page 27 by: Based on observations, record review, and interviews with staff and the Regional Consultant Registered Dietitian (RD), the facility failed to implement planned nutritional interventions and nutritional supplements recommended by the consultant RD and/or ordered by the physician for a resident with a significant weight loss. This was observed during 5 of 6 dining observations for 1 of 5 residents reviewed for nutrition (Resident #9). The findings included: Resident #9 was admitted to the facility on 3/28/17. Her cumulative diagnoses included Alzheimer ' s disease. The resident ' s electronic medical record reported the following weight history: 4/9/19 weight = 103.6 pounds (#); 8/5/19 weight = 98.8#. On 9/12/19, a Dietary Note indicated resident #9 ' s current weight was 90.4#. She was identified as having experienced a significant weight loss of 8.5% in one month and 13.2% over the past 6 months. The resident was reported to be receiving a regular diet with pureed textures, fortified foods (foods with added calories and protein), and ice cream at dinner for extra calories. Resident #9 ' s weight on 10/10/19 was recorded as 92.6#. On 11/3/19, a Nutrition Quarterly Note indicated the resident consumed 0 - 100% meals. She was reported as receiving fortified foods, House	F 692	F692 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. Resident #9 was reviewed by the Dietitian on 2/13/20 and no changes were made to the diet regimen. The tray ticket for resident #9 was updated to include the house shake at each meal on 3/6/20. The resident is now receiving whole milk and health shakes as ordered. The Dietary Staff and the Certified Nursing Assistants (CNAs) were in-serviced by the Director of Nursing or designee on 3/6-3/11/20 regarding the correct method for reading meal tickets to ensure accuracy of meals served. Recommendations by the Consultant RD/DTR based on nutrition assessments of residents will be forwarded to the Dietary and Nursing Departments to ensure the recommendations are entered into Point Click Care (PCC) and the Electronic Diet Office System (EDOS). The recommendations will be signed off as completed by the Dietary Manager. Monthly audits will be completed by the Consultant RD/DTR of 15 residents until	

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F 692	Continued From page 28 Shakes (a high calorie and protein nutritional supplement) twice daily, and ice cream with dinner for extra calories. No new recommendations were made at that time. The resident ' s electronic medical record reported the following weight history: 11/9/19 weight = 90.6#; 1/9/20 weight = 88.4#. A Nutrition Comprehensive Evaluation / Risk Screen was completed for Resident #9 by the facility ' s consultant Registered Dietitian (RD) on 1/27/20. The evaluation indicated the resident was severely underweight for age. Notes indicated she received House Shakes twice daily, fortified foods three times daily with meals, and ice cream with dinner. Resident #9 ' s nutritional needs were estimated and it was reported her intake of meals and supplements were not adequate to meet the estimated needs. The RD's recommendations included increasing the House Shakes provided from twice daily to three times daily with meals. A review of Resident #9 ' s annual Minimum Data Set (MDS) dated 2/1/20 indicated the resident had severely impaired cognitive skills for daily decision making. She required supervision from staff for eating. Section K of the MDS assessment revealed the resident weighed 88#. She was identified as having experienced a significant weight loss. Resident #9 ' s comprehensive care plan included an area of focus related to her risk for nutrition/dehydration. Interventions included, in part, the provision of nutrition interventions as ordered (initiated on 3/29/17; revised on 1/27/20).	F 692	100% compliance is maintained for two consecutive months, to ensure orders in PCC match items in EDOS. Items will be corrected as necessary. In additionResults of those audits will be shared with the Administrator, DON, and Dietary Manager. The Dietary Manager will report outcomes of those audits to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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The resident ' s current Order Summary Report dated 2/13/20 indicated physician ' s orders included the provision of a regular diet with pureed textures, thin liquids with no straw, and fortified foods for weight. Her dietary supplements included an order dated 1/27/20 for House Shakes three times a day.

An observation was conducted on 2/10/20 at 12:54 PM as Resident #9 was sitting in a wheelchair in her room with her meal tray placed on a bedside tray table in front of her. Resident #9 did not respond verbally when spoken to. The resident was observed to be eating her dessert (pudding) only; no other menu items appeared to have been consumed. The resident ' s meal card indicated whole milk should be on her meal tray, but it was not. Although there was a physician ' s order for a House Shake to be provided, the meal card did not indicate a House Shake would be sent on the tray. No House Shake was provided with the meal.

On 2/11/20 at 9:00 AM, an interview with Nursing Assistant (NA) #3 and an observation of Resident #9 ' s breakfast meal tray was conducted. Upon inquiry, the NA confirmed the resident fed herself breakfast with 100% meal intake. The resident ' s breakfast meal card indicated a House Shake would be sent with her meal, but it was not.

An observation was made of Resident #9 on 2/11/20 at 12:15 PM as she was sitting in a wheelchair in her room with her meal tray placed on a bedside tray table in front of her. The resident ' s meal card indicated whole milk should be on her meal tray, but it was not. Although there was a physician ' s order for a House Shake

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to be provided, the meal card did not indicate a House Shake would be sent on the tray. No House Shake was provided with the meal.

An observation was made on 2/11/20 at 6:25 PM of Resident #9 sitting in her wheelchair with the evening meal tray placed on a bedside tray table in front of her. A family member of the resident was visiting at the time of the observation. The family member reported Resident #9 was a small eater and stated she tended to prefer desserts and House Shakes over other foods and beverages. The resident ' s meal card indicated both whole milk and a House Shake would be on the meal tray. The resident's meal tray included a House Shake, but it did not include whole milk.

An observation was made of Resident #9 on 2/12/20 at 8:30 AM as she was sitting in a wheelchair in her room with her breakfast meal tray placed on a bedside tray table in front of her. Both a carton of whole milk and a House Shake were included on her breakfast meal tray in accordance with the planned dietary interventions and/or physician orders.

An observation was made on 2/13/20 at 8:35 AM of Resident #9 sitting in a wheelchair in her room with her breakfast meal placed on a bedside tray table in front of her. The resident ' s breakfast meal card indicated both whole milk and a House Shake would be on the tray. Whole milk was observed to be on the breakfast tray; however, no House Shake was sent with the meal.

An interview was conducted with NA #3 on 2/13/20 at 8:40 AM. NA #3 reported she herself had delivered the breakfast tray to Resident #9 that morning. When informed a House Shake

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was not on the resident ' s meal tray, the NA reported she was not aware of this. When asked, the NA recalled the House Shake had been left off of Resident #9's meal tray on other occasions in the past. The NA stated nursing staff could go to the Dietary Department to get a House Shake for the resident if it was not sent with the meal.

An interview was conducted on 2/12/20 at 9:10 with the facility ' s contract Dietary Manager. During the interview, the Dietary Manager reviewed Resident #9 ' s meal card from her electronic record. He reported the dietary records for this resident indicated she should receive fortified cereal for breakfast, whole milk with each meal, and fortified cream soup for supper. Her dietary records also indicated Resident #9 was supposed to receive a House Shake on her Breakfast and Supper meal trays (only twice daily). A follow-up interview was conducted with the Dietary Manager on 2/13/20 at 10:40 AM. During this interview, concerns regarding missing whole milk and House Shakes from Resident #9 ' s meal trays were discussed. When inquiry was made as to why Resident #9 ' s trays did not include a House Shake when they were intended, he stated, "It is dietary's responsibility to get the House Shake on the tray."

The facility ' s consultant RD was not available for an interview. An interview was conducted on 2/14/20 at 8:04 AM with the Regional Consultant RD. Upon review of Resident #9 ' s records, the RD confirmed Resident #9 had a significant weight loss which was first identified in September, 2019. Notes indicated when the facility ' s consultant RD reviewed the resident for her annual MDS on 1/27/20, the RD recommended House Shakes be provided three

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F 692	Continued From page 32 times daily with meals. A physician ' s order was written on 1/27/20 to provide House Shakes three times daily in accordance with this recommendation. On 2/14/20 at 8:43 AM, a follow-up interview was conducted with the Regional Consultant RD. The Regional Consultant RD confirmed Resident #9 ' s meal cards only indicated House Shakes would be provided at breakfast and dinner. However, House Shakes should have been sent from the Dietary Department three times daily (one with each meal) in accordance with the RD's recommendations and current physician ' s order dated 1/27/20.	F 692		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		3/13/20

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F 755	Continued From page 33 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record reviews, the facility failed to acquire an antianxiety medication for a period of four days to meet the needs for 1 of 7 residents (Resident #319) whose medications were reviewed. The findings included: Resident #319 was admitted to the facility on 10/30/18 with re-entry from a hospital on 3/1/19. His cumulative diagnoses included a degenerative disorder of the nervous system, non-Alzheimer ' s dementia, anxiety disorder, and depression. A review of the resident ' s hospital discharge medications dated 3/1/19 included 0.5 milligrams (mg) clonazepam (an antianxiety medication) to be given as 1 tablet by mouth scheduled twice daily. His admission medication orders to the facility also included 0.5 mg clonazepam given by mouth twice daily and scheduled for administration at 9:00 AM and 9:00 PM. Clonazepam is a controlled substance medication.	F 755	F755 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. Resident #319 no longer resides at the facility so no corrective action can be completed for this resident. Any resident receiving medications have the potential to be affected. A Medication Administration Record (MAR) to cart audit was completed by the administrative nursing team or designee on 3/6-3/9/20 to determine if any medications were missing from the cart and medications were ordered as necessary. The licensed nurses were in-serviced by the Staff Development Coordinator (SDC)	

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F 755	Continued From page 34 Resident #319 was admitted to Hospice on 5/10/19. At that time, the resident ' s clonazepam continued to be given twice daily but was rescheduled for 1:00 PM and 9:00 PM. Review of the resident ' s May 2019 Medication Administration Record (MAR) and electronic medical record revealed the following: --0.5 mg clonazepam scheduled for administration on 5/11/19 at 1:00 PM was not given. A medication administration note dated 5/11/19 at 3:01 PM indicated the resident was sleeping in the afternoon and the "med not here." --0.5 mg clonazepam scheduled for administration on 5/11/19 at 9:00 PM was not given. A medication administration note dated 5/11/19 at 8:29 PM indicated the medication was, "not available, need hard script for refill." --0.5 mg clonazepam scheduled for administration on 5/12/19 at 1:00 PM was checked as having been given. No corresponding medication administration note was written. --0.5 mg clonazepam scheduled for administration on 5/12/19 at 9:00 PM was not given. A medication administration note dated 5/12/19 at 9:46 PM indicated the medication was, "not available." --0.5 mg clonazepam scheduled for administration on 5/13/19 at 1:00 PM was not given. A medication administration note dated 5/13/19 at 12:21 PM indicated the medication was "on order." --0.5 mg clonazepam scheduled for administration on 5/13/19 at 9:00 PM was held. --0.5 mg clonazepam scheduled for administration on 5/14/19 at 1:00 PM was not given. A medication administration note dated 5/14/19 at 12:07 PM reported, "confirmed order	F 755	or designee on 3/6-3/11/20 regarding the process for reordering medications as the medications start to run low rather than waiting until they run out, what to do if a medication was not available on the medication cart such as calling the pharmacy to have the medication sent out STAT, calling the pharmacy to contact physician for a hard script for a narcotic or contacting the physician themselves. They were also taught to call the physician to see if they could obtain an order for an alternative medication that the facility had in stock could be given until the originally ordered medication became available. The licensed nurses will complete weekly audits of the medication carts on Wednesday to determine what medications needed to be reordered to prevent the resident from running out of the medications and will reorder medications as necessary. Reordering medication and what to do if a medication is not available has been added to the orientation process for the licensed nurses. The Administrative Nursing Team will conduct MAR to cart audits of five residents per cart per week until 100% compliance is maintained for two consecutive months to ensure medications are available at all times. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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coming tonight from pharmacy."
--0.5 mg clonazepam scheduled for administration on 5/14/19 at 9:00 PM was not given. A medication administration note dated 5/14/19 at 10:17 PM read, "Pharmacy contacted delivery in route."

A review of the resident ' s May 2019 MAR documented that on 5/14/19 at 10:16 PM the resident received a one-time dose of 2 mg/ml lorazepam (an antianxiety medication) given as 0.5 mg injected intramuscularly for anxiety.

Resident #319 ' s Controlled Medication Utilization Records (a declining inventory record) included a record dated 5/13/19. This record was labeled by the pharmacy to indicate a quantity of 30 tablets of 0.5 mg clonazepam was filled for Resident #319 on 5/13/19. Documentation on the record included a handwritten date to indicate the clonazepam was received by the facility on 5/15/19.

A telephone interview was conducted on 2/13/20 at 10:00 AM with the Pharmacist in Charge at the facility's dispensing pharmacy. During the interview, the pharmacist was asked to review the dispensing history for Resident #319's 0.5 mg clonazepam. The pharmacy records indicated (in part) 60 tablets of 0.5 mg clonazepam were dispensed by the pharmacy on 4/10/19; then 30 tablets of 0.5 mg clonazepam were dispensed on 5/13/19 for the resident. Upon inquiry, the pharmacist reported the facility's automated medication dispenser did not stock clonazepam. She stated if a resident ran out of clonazepam, the pharmacy would need to STAT (immediately send) out the medication. Alternatively, the pharmacy could utilize a local pharmacy as their

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backup if the medication was urgently needed. If the facility did not have a hard script for the clonazepam, the physician could e-prescribe the medication, call in a verbal order for the med, or possibly call in an order for an appropriate alternative medication stocked at the facility.

A telephone interview was conducted with Nurse #6 on 2/13/20 at 1:11 PM. Nurse #6 was identified by her initials on Resident #319 ' s MAR as being responsible to administer his clonazepam scheduled for 5/11/19 at 1:00 PM and 5/12/19 at 1:00 PM. Nurse #6 reported she was a weekend nurse for the facility. Upon inquiry, the nurse reported she did not specifically recall this resident or the situation when he was scheduled to receive a dose of clonazepam but was out of the medication. When asked what she would typically have done in such a situation, Nurse #6 stated she hoped she would have checked the facility ' s stock medications for clonazepam in the automated medication dispensing machine. If not there, then she would try to call the pharmacy if there were refills remaining on the prescription. If no refills were left and she needed a new hard script for the medication, Nurse #6 stated she probably would have left a message for the Monday morning physician (or perhaps called the provider if she felt it was critical to do so).

Multiple unsuccessful attempts were made to contact Nurse #7 for a telephone interview. Nurse #7 was an agency nurse who was no longer assigned to work at the facility. She was identified by her initials on Resident #319 ' s MAR as being responsible to administer his clonazepam scheduled for 5/11/19 at 9:00 PM and 5/12/19 at 9:00 PM.

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A telephone interview was conducted with Nurse #8 on 2/13/20 at 12:25 PM. Nurse #8 was identified by his initials on Resident #319 ' s MAR as being responsible to administer the resident ' s clonazepam scheduled for 5/13/19 at 1:00 PM and 5/14/19 at 1:00 PM. Nurse #8 reported he did not recall this resident or the situation when he was scheduled to receive clonazepam but was out of the medication. When asked what he typically would have done in this type of a situation, the nurse stated he would go and check the back-up medications to see if clonazepam was available in the facility. If not, he would notify the physician and get a hard script for the medication as soon as possible.

A telephone interview was conducted with Nurse #11 on 2/13/20 at 12:20 PM. Nurse #11 was identified by his initials on Resident #319 ' s MAR as being responsible to administer the resident ' s clonazepam scheduled for 5/13/19 at 9:00 PM. During the interview, the nurse reported he did not recall this resident. He stated he worked as a contract nurse (not employed by the facility). Upon further inquiry, Nurse #11 reported he could not access the facility ' s automated dispensing machine because he did not have a "PIN" number to do so.

Multiple unsuccessful attempts were made to contact Nurse #9 for a telephone interview. Nurse #9 was identified by her initials on Resident #319 ' s MAR as being responsible to administer his clonazepam scheduled for 5/14/19 at 9:00 PM.

A telephone interview was conducted on 2/14/20 at 11:01 AM with the facility ' s consultant

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pharmacist. During the interview, the pharmacist was able to access Resident #319 ' s electronic medical records. Upon review of his May 2019 MAR, the pharmacist confirmed the records appeared to indicate clonazepam was not available for administration to the resident from 5/11/19 to 5/14/19. When asked, the pharmacist stated she thought the likelihood of the resident having withdrawal symptoms by missing the medication for 4 days may be low due to the long half-life of this drug. However, the pharmacist reported she "definitely" thought nursing staff should have contacted the physician to obtain a hard copy of a prescription and/or perhaps considered an alternative, in-stock medication such as lorazepam until the clonazepam could be obtained.

An interview was conducted on 2/19/20 at 12:19 PM with the facility's Director of Nursing (DON). During the interview, concerns regarding the facility failure to acquire Resident #319 ' s clonazepam to meet his needs between 5/11/19 - 5/14/19 were shared. Upon inquiry, the DON discussed the process she wanted facility nurses to follow if a resident was out of a controlled substance medication. The DON reported she would expect the nurses to contact the physician in one of two ways. First, nurses could call the pharmacy and the pharmacy would contact the physician for a hard script. Or alternatively, nurses could call the physician directly, then the physician could contact the pharmacy and provide a hard script for a controlled substance medication that way. The DON added the nurses were also taught to see if there was an alternative medication stocked in-house that could be given to the resident (with a physician ' s order) until the resident ' s medication became available.

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 medication opportunities, resulting in a medication error rate of 8% for 2 of 5 residents (Resident #38 and Resident #112) observed during medication pass. The findings included: 1) Resident #38 was admitted to the facility on 8/12/19. Her cumulative diagnoses included dysphagia following a cerebral infarction (stroke) and placement of a gastrostomy tube (a tube placed into the stomach for nutritional support and/or medication administration). On 2/12/20 at 8:02 AM, Nurse #3 was observed as she prepared medications for administration via a gastrostomy tube to Resident #38. The medications included the following: --1 tablet of 220 milligrams (mg) zinc sulfate (a mineral supplement); --1 chewable tablet of 81 mg aspirin; --1 tablet of 12.5 mg carvedilol (a blood pressure medication); --1 tablet of 20 mg famotidine (a medication used to reduce stomach acid); --1 tablet of 20 mg furosemide (a diuretic);	F 759	F759 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. Nurse #3 that administered medications to resident #38 was in-serviced by the DON on 2/12/20 regarding the process for administering medications via gastrostomy tube including flushing the tube before, between and after medications are administered. Nurse #2 that administered the medication to resident #112 was in-serviced by the DON on 2/13/20 regarding the six rights of medication administration and ensuring the right dose is being administered. There was no negative outcome to either resident. Any resident receiving medication has the potential to be affected. A medication pass observation of the licensed nurses have been completed starting 2/18/20 by	3/13/20

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F 759	Continued From page 40 --1 tablet of 50 mg losartan (a blood pressure medication); --10 milliliters (ml) of 100 mg/1 ml levetiracetam solution (an anticonvulsant medication); --15 ml of 10 mg/1 ml lacosamide solution (an anticonvulsant medication). Each medication in tablet form was crushed individually and placed in a separate medication cup. After all medications were prepared for administration, Nurse #3 was observed as she brought the medications and approximately 6 ounces of water in a cup into Resident #38 ' s room. The nurse checked the placement of the gastrostomy tube with a stethoscope. She was then observed as she added approximately 10 ml of water to each medication cup containing a crushed tablet, stirring with a spoon to dissolve the medication. The nurse was observed as she administered the first dissolved medication. She did not flush the tube with water prior to this medication administration. Each of the next four dissolved medications were administered without a water flush between the medications. After the 5th medication was poured into the gastrostomy tube, the dissolved medication was observed to slowly pass through the tube. The 6th dissolved medication poured into the tube also drained slowly, as did the 7th medication (a solution). When it was time to administer the 8th medication to the resident (also a solution), the nurse added approximately 5 to 10 ml of water to the liquid medication prior to instilling it into the gastrostomy tube. Once all medications were administered, 15 ml of water were used to flush the tubing. An interview was conducted on 2/12/20 at 11:20 AM with Nurse #3 in regards to the observation of Resident #38 ' s medication administration via	F 759	the Staff Development Coordinator (SDC) to ensure medications are being administered properly. Any nurse failing to achieve a medication error rate of 5% or less after two medication pass observation will be removed from the schedule until the demonstrate the ability to pass medications with 5% or less error rate. The licensed nurses were in-serviced by the pharmacy consultant and SDC on 2/26/20 and 3/6-3/11/20 regarding the six rights of medication administration and proper medication administration via gastrostomy tube. Licensed nurses will be required to pass a medication administration observation and competency with 5% or less error rate during their orientation process prior to being released to pass medications. The SDC will complete at least three medication pass audits weekly to ensure 100% of licensed nurses are maintaining a 5% or less error rate consistently over a two month period. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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gastrostomy tube. During the interview, the nurse was asked why she did not flush the resident ' s gastrostomy tube prior to the med administration. The nurse stated she did not flush the tube because the resident ' s tube feeding was provided as a continuous feed. Upon further inquiry, the nurse further stated she did not flush the tubing with water between each of the medications because there was not a physician ' s order which indicated she needed to do so.

A review of Resident #38 ' s current physician orders revealed there was not an order which contraindicated the use of a water flush prior to and between medications administered via the gastrostomy tube.

An interview was conducted on 2/12/20 at 11:30 AM with the facility ' s Director of Nursing (DON). During the interview, the observation of Resident #38 ' s medication administration via her gastrostomy tube was discussed. The DON reported she would expect the nurse to flush a resident's gastrostomy tube prior to medication administration and, to also use water to flush between each individual medication administered.

2) Resident #112 was admitted to the facility on 9/3/18. Her diagnoses included allergies.

On 2/13/20 at 8:22 AM, Nurse #2 was observed as she prepared and administered medications to Resident #112. The medications included Aller-ease tablet 60milligrams, 2 tablets.

A review of Resident #112 ' s medication orders included the following, "Mucinex Allergy tablet 180 milligrams daily for allergy", ordered on 2/21/19 at

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F 759	Continued From page 42 9:00 AM. An interview was conducted with Nurse #2 on 2/13/20 at 8:30 AM. During the interview, Nurse #2 stated she realized after she administered the medication she should have given 3 tablets per the physicians order instead of 2.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the	F 761	F761	3/13/20

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F 761	Continued From page 43 facility: 1) Failed to label medications with the minimum required information, including the resident ' s name and expiration date on 1 of 3 medication carts (500 Hall med cart); and, 2) Failed to store medications as specified by the manufacturer on 1 of 3 medication carts (400 Hall med cart) observed. The findings included: 1-a) Accompanied by Nurse #11, an observation was conducted on 2/11/20 at 10:35 AM of the 500 Hall medication cart. The observation revealed a dropper bottle of 100 milligrams (gm) / 5 milliliters (ml) morphine sulfate (an opioid pain medication) labeled for Resident # 64 was stored on the medication cart in a brown, light protective bag. Pharmacy labeling on the bottle indicated the medication was dispensed on 11/25/19. No expiration date could be found on the bottle or on the labeling of the brown plastic bag it was stored in. Upon review of the morphine bottle and bag, Nurse #11 confirmed no expiration date could be found on the labeling. Upon request, an interview was conducted on 2/11/20 at 10:50 AM with the facility ' s Administrator and Director of Nursing (DON). During the interview, the DON reviewed the labeling on the bottle and bag containing the morphine sulfate. No expiration date was found. The DON reported she would need to contact the pharmacy for further information on the expiration date of this medication. 1-b) Accompanied by Nurse #11, an observation was conducted on 2/11/20 at 10:35 AM of the 500 Hall medication cart. The observation revealed an opened vial of Humalog insulin was stored in a	F 761	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. No residents were found to be affected by the expired or undated medications located on the medication carts. The medications were removed upon notification from surveyor. Any resident receiving medication has the potential to be affected. A thorough inspection of all facility medication carts was conducted by the Administrative Nursing Team on 2/11/20 to ensure there were no expired or undated medications noted on the on the medication carts The licensed nurses were in-serviced by the Staff Development Coordinator or designee regarding checking the medication cart prior to the start of their medication pass for expired and undated medications on 3/6-3/11/20 and will be added to the orientation agenda. The medication carts will be checked every Wednesday by the licensed nurses for expired medications as part of the medication reorder review. The Director of Nursing or designee will complete audits of all medication carts weekly to check for expired or undated	

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F 761	Continued From page 44 drawer of the medication cart (separated from other insulins stored on the med cart). The resident's name on the label of the vial was marked through with a black marker and was not legible. Handwritten dates on the label of the insulin vial read, "2/2/20-3/7/20." Upon inquiry, Nurse #11 reviewed the labeling and stated he did not know who this insulin had been used for. The nurse reported he would need to discard it. An interview was conducted on 2/14/20 at 12:19 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of med storage were discussed. The DON stated the opened vial of insulin (not labeled with a resident ' s name) should have been discarded. 2-a) Accompanied by Nurse #10, an observation was conducted on 2/11/20 at 10:05 AM of the 400 Hall medication cart. The observation revealed 2 - unopened Lantus Solostar pens and 1 - unopened Humalog vial dispensed from the pharmacy on 2/10/20 were stored on the med cart. Neither the insulin pens nor the vial of insulin were dated as to when they were placed on the med cart. At the time of the observation, Nurse #10 reported unopened insulin pens and vials should be stored in the med room refrigerator until needed. A review of the manufacturer's storage instructions for both the Lantus Solostar pens and vial of Humalog insulin indicated unopened vials and prefilled pens should be refrigerated until the expiration date, or at room temperature for 28 days. Upon request, an interview was conducted on 2/11/20 at 10:45 AM with the facility ' s	F 761	mediations until 100% compliance is maintained for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 761	Continued From page 45	F 761		

Administrator and Director of Nursing (DON). During the interview, the DON stated the insulins should be dated when they are put on the cart. She reported unopened insulin vials and pens were normally stored in the refrigerator.

2-b) Accompanied by Nurse #10, an observation was conducted on 2/11/20 at 10:05 AM of the 400 Hall medication cart. The observation revealed a box of 0.5 milligrams (mg) / 2 milliliters (ml) budesonide solution vials for nebulization (a corticosteroid for inhalation) was stored on the medication cart. Pharmacy labeling on the box indicated the box was dispensed on 1/23/20. One opened pouch was lying in the box. The opened pouch was empty; it was not dated as to when it had been opened. One vial of solution was found lying underneath the opened foil pouch. The manufacturer labeling on the budesonide solution for nebulization read, in part "Once foil pouch is opened, use the vials within 2 weeks ...store unopened vials in the foil envelope ..."

An interview was conducted on 2/14/20 at 12:19 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of med storage were discussed. The DON stated the nursing staff had been taught to store vials of nebulizer solution in the foil pouch, and typically to have the pouch dated as well.

2-c) Accompanied by Nurse #10, an observation was conducted on 2/11/20 at 10:05 AM of the 400 Hall medication cart. The observation revealed a box of 0.5 milligrams (mg) / 2.5 milliliters (ml) ipratropium solution vials for nebulization (an inhaled medication used to manage chronic obstructive pulmonary disease) was stored on the

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F 761	Continued From page 46 medication cart. Pharmacy labeling on the box indicated the box was dispensed on 1/2/20. An empty, opened foil pouch and two vials of solution were observed lying on the bottom of the box (not stored in the pouch). The manufacturer labeling on the ipratropium solution for nebulization read, in part: "Store unused vials in the foil pouch." An interview was conducted on 2/14/20 at 12:19 PM with the facility ' s Director of Nursing (DON). During the interview, the observations of med storage were discussed. The DON stated the nursing staff had been taught to store vials of nebulizer solution in the foil pouch, and typically to have the pouch dated as well.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide diet as prescribed by the physician and meet resident's needs for 1 of 5 residents reviewed for nutrition (Resident # 52). The findings include: Resident #52 was readmitted to the facility on 5/28/19 with diagnoses that included dementia and dysphagia. Review of the quarterly Minimum Data set (MDS) dated 1/7/20 revealed Resident # 52 was cognitively impaired, needed extensive	F 805	F805 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. Resident #52 was evaluated by the Speech Therapist on 2/13/20 to evaluate	3/13/20

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F 805	Continued From page 47 assistance with one-person physical assist for eating. Resident # 52's care plan dated 1/6/20 indicated the resident was at risk for malnutrition and dehydration related to dysphagia. The goal was to maintain adequate nutrition and dehydration. Interventions included mechanical soft texture with nectar thick liquid and encouraging meal, snack and fluid intake, Review of the physician order dated 1/27/20 revealed regular, mechanical soft texture, nectar/mildly thick fluid consistency for nutrition. During a continuous dining observation on 2/10/20 from 12:55 PM to 1:15 PM, Resident # 52 was observed in the dining room being fed by staff. Review of Resident # 52's meal ticket revealed mechanical soft and nectar thick liquids. The beverages on the meal ticket indicated nectar milk and nectar water. Observation of the resident's tray revealed the resident was provided thin liquids. On 2/10/20 at 1:00 PM during an interview, Nurse aide (NA) # 4 who was assisting the resident with feeding, stated the resident was previously on a pureed diet and thickened liquids. She indicated the speech had evaluated the resident and had upgraded the resident to regular liquids few months ago. She stated she was unaware the resident was on nectar thick liquid. NA confirmed she did not check the meal ticket for fluid consistency. On 2/10/20 at 1:05 PM, during an interview NA# 5 who was serving resident's meals in the dining room stated they had not received any	F 805	for correct diet and no changes were made to the diet regimen (the resident would remain on thin liquids as ordered). The tray ticket for resident #52 was updated to include thin liquids as ordered at each meal on 2/13/20. The resident received thin liquid through her discharge date of 2/21/20. The Dietary Staff and the Certified Nursing Assistants (CNAs) were in-serviced by the Director of Nursing or designee 3/6-3/11/20 on the correct method for reading meal tickets to ensure accuracy of meals served and what to do if the tray ticket is incorrect. Recommendations by the Speech Therapist based on assessments of residents will be forwarded to the Dietary and Nursing Departments to ensure the recommendations are entered into Point Click Care (PCC) and the Electronic Diet Office System (EDOS). The recommendations will be signed off as completed by the Dietary Manager. Monthly audits will be completed by the Consultant RD/DTR of 15 residents until 100% compliance is maintained for two consecutive months, to ensure orders in PCC match items in EDOS. Items will be corrected as necessary. Results of those audits will be shared with the Administrator, DON, and Dietary Manager. The Dietary Manager will report outcomes of those audits to the steering QAPI committee monthly. The steering committee will direct further	

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F 805	Continued From page 48 communication from the nurse that the resident was on thickened liquid. NA stated she did not check the meal ticket for fluid consistency. During an interview 2/10/20 at 3:20 PM, Speech therapist stated Resident # 52 was discharged from speech therapy services for meeting her goals in October 2019. The recommendations at discharge were "regular solid food and regular thin liquids". Speech therapist further stated that the staff could downgrade a diet if any chewing or swallowing issues were observed, however, the resident should be referred to speech for further evaluation so that the resident could be prescribed an appropriate diet consistency. She indicated that the speech therapy department did not received any referrals for consistency downgrade and was unsure why the resident's diet was changed. During an interview with Director of Nursing (DON) on 2/10/20 at 4:00 PM, she stated she did speak to the Registered Dietitian (RD) and the RD was unsure why the diet was downgraded. The DON stated the RD was unavailable to be interviewed. On 2/13/20 at 11:20 AM during an interview, the consultant dietary manager stated the nursing staff assisting in the dining room during meals were responsible to check the fluid consistency of the residents. All beverages were offered by nursing staff in the dining room. The meal tickets were returned to the kitchen only after the residents were offered beverages. He indicated if any resident required a special consistency, the staff should notify dietary so that these beverages could be offered.	F 805	analysis and interventions based on reported outcomes and direct further investigations.	

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F 805	Continued From page 49 On 2/14/20 at 1:26 PM during an interview, the administrator stated that any recommendation from speech therapy and dietitian should be signed off by the physician and the physician's orders should be followed by staff. The administrator stated it was her expectation that the meal tickets were checked, and meals were served accurately to the residents.	F 805		
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 and staff interviews the facility failed to label and date stored food items, discard foods with expired expiration and expired use by dates and keep the refrigerator clean in 1 of 2 kitchen refrigerator units and in the kitchen's dry storage area they failed to keep the area	F 812	F 812 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of	3/13/20

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F 812	Continued From page 50 clean and ensure bread products were labeled so staff knew how long the bread could be utilized. Findings included: 1. Observations of foods stored in the kitchen's reach in refrigerator on 2/09/20 at 9:40 AM, with the dietary manager (DM), revealed the following: a. A plastic container with yellow colored food inside and labelled "use by 1/10/20". The consultant dietary manager indicated food inside the container was cheese sauce with a use by date 1/10 /20. He indicated that this food should have been discarded long ago. b. A plastic container which was half filled with a pink colored liquid with no label on it. A steel container containing brown colored liquid with no label. The consultant dietary manager indicated that the pink colored liquid was a beverage made from a mix and the liquid in the steel container was tea. He was unsure when these beverages were made. 2. Observations of the kitchen's walk-in refrigerator on 2/09/20 at 9:35 AM, with the DM, revealed the following: a. A transparent bin labelled " cheese only" containing multiple bags of cheese and a half-cut onion wrapped in a cling wrap placed in it. The bin contained 3 sandwich size Ziplocs with sliced cheese and an opened bag of shredded cheese with no label on them. The consultant dietary manager stated he was not sure when the cheese bags were open and their expiration dates. The refrigerator also contained an opened	F 812	deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. No residents were identified to be affected by the food storage in the reach in refrigerator, walk in refrigerator and the dry storage area. The plastic container with yellow colored food, the plastic container with pink liquid, the steele container containing brown liquid, the cheese and onion in the transparent bin, the open bag of salad, the 25 cartons of half pint chocolate milk, the 11 opened bags of hotdog burns, and the 2 bags of hamburger buns were discarded by the Dietary Manager at the time of survey when it was brought to his attention by the surveyor. The floor of the walk in freezer was cleaned by the Dietary Manager on 2/9/20 to remove the black spots. The paper towels and milk were also removed at that time. The floor of the dry storage area was cleaned by the Dietary Manager on 2/10/20 after it was brought to his attention by the surveyor. The flour bin was also cleaned at that time. The Dietary Manager will complete and document daily walk through of the kitchen, freezer, refrigerators, and dry storage to ensure the food is dated and stored properly and the areas are clean. A cleaning schedule was developed and posted to indicate staff responsible for cleaning each area. The Dietary Staff was in-serviced by the Dietitian on 3/6-3/11/20 regarding the proper labeling	

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F 812	Continued From page 51 bag of salad with no label on it. b. A crate containing 25 cartons of half pint chocolate milk with an expired expiration date of 2/9/20. The consultant dietary manager indicated that the expired milks should not be in the refrigerator and should be discarded. c. The floor of the refrigerator was dirty and had black spots on it. There were paper towels under the food storage racks and milk cartons were dropped on the floor. The consultant dietary manager indicated the staff should maintain the refrigerator clean. He stated the floor should be clean, and milk cartons should not be on the floor and should be picked up if dropped. During an interview on 2/12/20 at 11:55 AM, dietary cook # 2 stated it was the duty of all staff to clean up after themselves. She stated there was no cleaning schedule for cleaning the refrigerator. On 2/13/20 at 11:21 AM during an interview, the consultant dietary manager stated there was no cleaning schedules posted and hence no staff was responsible for cleaning the refrigerators. 3. Observations of the kitchen's dry storage area on 2/10/20 at 9:28 AM, with the consultant dietary manager, revealed the following: a. The floor of the dry storage area was not clean. There was paper on the floor. The flour bin had flour dropped on the lid and around it on the floor. The dietary manager indicated that the staff should clean the flour bin if they had dropped flour on and around it and should also be cleaning the flour regularly.	F 812	and storage of food and the cleaning schedule. The Administrator will audit by conducting random sanitation inspections in the kitchen at least 3 times weekly until 100% compliance regarding freezer and food labeling and kitchen cleanliness is maintained for at least two consecutive months. In addition, the Administrator or designee will review the cleaning schedule to cleaning is being completed as scheduled weekly until 100% compliance is maintained for 2 consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 812	Continued From page 52	F 812		

b. Observation of the bread rack in the dry storage area revealed 4 bags containing 4 hotdog buns each with a hand-written date of " 1/27/20 ", 7 bags containing 4 hotdog buns each with a hand-written date of "1/16/20", 1 bags containing 12 hamburger buns with a hand- written date of "1/16/20" and 1 opened bag containing 4 hamburger buns with a hand-written date of "1/16/20".

On 2/10/20 at 9:30 AM during an interview, the consultant dietary manager indicated the bread was received frozen. He stated the hand-written dates on the bags indicated the date the bread was removed from the freezer, thawed and was ready to use. The consultant dietary manager stated he did not know the expiration date on the bread. The dietary manager also indicated that the staff should be following first in and first out method when bread was removed from the racks for daily use.

2/12/20 at 11: 30 AM during an interview, dietary cook #1 stated she was unsure how long the bread could be placed on the bread rack after the bread was thawed for a meal. She indicated the date on the bread was the date it was removed from the freezer. She confirmed the packages of bread did not have any expiration date on them.

on 2/12/20 at 11:55 AM during an interview, dietary cook # 2 stated the bread was labelled with the date that indicated the date it was taken out from the freezer. She stated she did not know how long the bread could be out once thawed, but usually takes the exact amount of bread needed for the meal.

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F 812	Continued From page 53 During an interview on 2/12/20 at 1:00 PM, the consultant dietary manager, he stated he had contacted the food supplier and his corporate office related to expiration date and how long the bread after thaw can be on the bread racks and both did not have an answer for him. On 2/13/20 at 11:21 AM during an interview, the consultant dietary manager stated the facility did not have a policy for bread storage after it was thawed. He indicated he was unsure how long the bread could be stored. The dietary manager further stated that staff should labeling the bread with an out date and a use by date. Staff should be checking expiration dates and discarding food appropriately.	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility's Quality's Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification and complaint survey conducted on 3/14/19. This was for recited deficiencies in the areas of accuracy of assessments (F641) and label/store drugs and biologicals (F761). These deficiencies were recited during an annual	F 867	F867 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.	3/13/20

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F 867	Continued From page 54 recertification and complaint survey conducted on 2/14/20. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. The findings included: This tag is cross referenced to: 1) F641 - Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of: 1. Dialysis for 1 of 2 residents (Resident #58) reviewed who received dialysis; and 2. Medications for 1 of 5 residents (Resident #83) reviewed for unnecessary medications. During the facility's annual recertification and complaint investigation on 3/14/19 the facility was cited for F641 for failing to accurately code the discharge Minimum Data Set (MDS) assessment to reflect the discharge status for 1 of 8 residents reviewed for assessment accuracy (Resident #107). The facility ' s Administrator and Director of Nursing (DON) were interviewed on 2/14/20 at 1:51 PM. During the interview, the Administrator reported the facility identified some concerns during a recent mock survey. One of the issues identified during the mock survey was related to Minimum Data Set (MDS) assessment accuracy. The MDS and care plan team have since been in-serviced. However, the Administrator acknowledged corrections to the assessments were not completed prior to initiation of the annual recertification and complaint survey. The Administrator and DON reported citations would	F 867	Facility held an ad hoc QAPI meeting on 3/10/20 to review previous and current citations regarding assuring professional standards of practice are followed and having an effective QA program. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. QAPI team members were in-serviced by the Administrator/DON on 2/19/20. The education included the QA program review of previous survey citations and the inclusion of on-going monitoring to maintain compliance. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. The Administrator will document in the QAPI minutes the monthly review of on-going QAPI plans with the QAPI team for three months and as needed. The Administrator will be responsible for implementing the Plan of Correction (POC). The QAPI committee will review the results of the audits monthly for three months and as needed thereafter.	

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F 867	Continued From page 55	F 867		

be reviewed by the facility ' s Quality and Assurance Performance Improvement (QAPI) committee to ensure they were corrected.

2) F761 - Based on observations and staff interviews, the facility: 1) Failed to label medications with the minimum required information, including the resident ' s name and expiration date on 1 of 3 medication carts (500 Hall med cart); and, 2) Failed to store medications as specified by the manufacturer on 1 of 3 medication carts (400 Hall med cart) observed.

During the facility's annual recertification and complaint survey conducted on 3/14/19 the facility was cited for F761 for failing to provide the expiration date for three medications on 1 of 5 medication administration carts (200 hall); failed to remove one expired insulin multi dose vial from 1 of 5 medication administration carts (500 hall); failed to provide the date of opening for 2 insulin pen injectors in 1 of 5 medication administration carts (500 hall) and 2 insulin multi-dose vials in 1 of 5 medication administration carts (300 hall).

The facility ' s Administrator and Director of Nursing (DON) were interviewed on 2/14/20 at 1:51 PM. During the interview, the Administrator reported the facility had a pharmacy consultant come in and completed a quarterly review a few weeks before the survey. The review included observations of medication storage and in-servicing with staff on medication storage (including the storage and dating of insulin pens). The Administrator and DON reported citations would be reviewed by the facility ' s Quality and Assurance Performance Improvement (QAPI) committee to ensure they were corrected.

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