STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING ______ B. WING ______	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/10/21 through 04/14/22. The facility was found in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #8HYB11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 04/10/21 through 04/14/22. 3 of the 23 complaint allegations were substantiated resulting in deficiencies. Intakes, NC 00185627, NC 00186466, NC00186799, NC 00186897, NC00186906, NC 00187658, NC 00187971. Event ID #8HYB11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences 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 resident and staff interviews, and record review, the facility failed to provide Resident #87 with the correct size briefs for 1 of 4 sampled residents reviewed for accommodation of needs. The findings included: Resident #87 was admitted to the facility on 2/4/22 and discharged home on 3/3/22.	F 558	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following	5/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/06/2022

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

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F 558	Continued From page 1 An admission Minimum Data Set assessment dated 2/14/22 revealed Resident #87's cognition was intact, required extensive 2-person assistance with bed mobility, toileting and had frequent incontinence of bowel and bladder. A care plan 3/1/22 revealed Resident #87 had bladder incontinence related to impaired mobility and activity intolerance. A telephone interview with the Resident #87 on 4/11/22 at 3:07 pm revealed he brought 48 bariatric briefs with him when he arrived at facility on 2/4/22 and ran out of the briefs within two weeks. He further revealed an unknown staff person showed him the order form showing the facility ordered and received bariatric briefs in a timely manner. Resident #87 could not recall the day he was shown the order form. He indicated he did not receive the bariatric briefs until two (2) days before he discharged from the facility and until then staff provided him with briefs that were too small and uncomfortable. He further indicated he asked a Nurse Aide (unknown) for the briefs and was told the supply clerk was out of the facility and supplies were not being distributed. Resident #87 indicated he saw a pallet of supplies outside the back of the building and was told by an unknown staff member that the supply clerk was the only one who could unload and distribute the supplies. He further indicated he was told that the supply clerk was out of the facility for almost 2 weeks. He also spoke with a unit manager who no longer worked at the facility. Resident #87 revealed he had skin irritations prior to wearing the briefs that were too small, although wearing the too small briefs did not improve skin irritation.	F 558	plan of correction constitutes the facilitys allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F558 Reasonable Accommodations needs How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #87 is no longer a resident of the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Current bariatric patients have the potential to be affected by the alleged deficient practice. Central supply clerk completed audit of current bariatric patients to validate correct size briefs are available for resident. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Admission Coordinator will be educated to notify Central Supply Clerk of a Bariatric patient admission by Director of Nursing or designee Completion 5/3/2022 Central Supply clerk has been educated	

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F 558	Continued From page 2 An interview with Central Supply Clerk on 4/12/22 at 2:11 pm indicated she started working at the facility in February 2022 and could not recall the issue regarding Resident #87 not receiving the correct briefs. She further indicated if needed supplies were on back order, the facility would normally contact a Medline liaison for assistance or contact a nursing home affiliate to obtain needed supplies such as briefs. The Central Supply Order notebook was reviewed during the interview and revealed bariatric briefs were ordered on 2/10/22 and 2/18/22. Further review of the notebook did not indicate order received dates. The Central Supply Clerk indicated she was in training and could not recall if she ordered the briefs on 2/10/22 and 2/18/22. An interview with Nurse Aide (NA) #4 on 4/13/22 at 3:32 PM revealed she cared for Resident #87 during his nursing home stay. She recalled Resident #87 requested bariatric briefs, but his correct size was unavailable. NA #4 further revealed Resident #87 stated he was running out of the bariatric briefs he brought with him at the time of admission to facility. NA #4 indicated she asked the staff person in central supply if the requested briefs were ordered and available. NA #4 could not recall the date she went looking for the larger briefs and could only recall the correct size briefs were not available for Resident #87, therefore, she used the largest size the supply room had available. Interviews with other nursing staff revealed they did not work with Resident #87 or were not familiar with his situation. An interview with the Administrator on 4/12/22 at 4:28 pm revealed Resident #87 brought his own bariatric briefs into the facility upon admission.	F 558	to provide proper brief sizing to all new Bariatric patients and stock supply in room and Central Supply storage area by Director of Nursing or designee, Completion 5/3/2022. DON and or designee will audit Bariatric patient□s brief supply weekly X 4, Bi-weekly X 1 month, and monthly X 1 for proper size availability in room and central supply storage area. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of audits will be reviewed in Quarterly Quality Assurance Meeting X 1 for further problem resolution if needed. Completion date: 5/16/2022	

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F 558	Continued From page 3 When Resident #87 was about to run out of bariatric briefs, the facility placed an order for bariatric briefs on 2/18/22 and the order was received on 2/21/22. An additional order was placed on 2/25/22 and delivered on 2/28/22. The Administrator provided an email copy of the Medline Proof of Delivery receipt that indicated bariatric briefs (1 carton of 32 briefs) were received at the facility on 2/14/22. No other Proof of Delivery receipts could not be located. The Administrator was unaware Resident #87 did not receive the briefs for at least 2 weeks after facility received the order.	F 558		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 565		5/16/22

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F 565	Continued From page 4 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on a review of Resident Council (RC) Minutes (February 2022 and March 2022), a RC Meeting (April 2022), and interviews with staff, the facility failed to document resolution to RC concerns (February 2022), and resolve concerns voiced by residents during RC Meetings for 3 of 5 months reviewed (February 2022, March 2022, and April 2022). The findings included: 1 a. A review of RC Minutes for February 2022 and March 2022, revealed Residents who attended the meetings voiced the following concerns: ·February 1, 2022 - 6 of 6 residents voiced nursing did not consistently return menus to residents for selection of their menu choices. There was no documentation of follow up to this concern. ·March 1, 2022 - 4 of 4 residents voiced they were not getting menus to select their menu choices on a regular basis. Documentation for follow up recorded that the new system would have assigned dietary and nursing staff hand out	F 565	F565 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: One of the 6 residents is no longer a resident at the facility. Five of the six residents are now receiving meal selection tickets to choose their meal options daily and receiving selected items. How facility will identify other resident having the potential to be affected by the same deficient practice. Current residents have the potential to be affected by the alleged deficient practice. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Resident council minutes for the last 4 months were audited by administrator to ensure response and resolution has been implemented. Administrator held resident council meeting on 5/5/22 to discuss resolution to concern of meal tickets that	

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F 565 Continued From page 5

and collect all menus.

1 b. During a RC meeting held on 4/12/22 at 10:47 AM, 6 of 6 residents voiced that their previous concerns, from the February 2022 and March 2022 RC meetings, regarding receiving menus consistently to choose their menu items, still was not resolved. Residents who attended the 4/12/22 RC Meeting expressed this concern occurred as recently as Saturday, 4/9/22 and Sunday, 4/10/22.

The Dietary Manager (DM) was interviewed on 04/12/22 at 1:05 PM and stated he was the DM since 3/3/22. He stated that he was made aware that before he started, residents stated during RC meetings that they did not like the menu selection system in place so now he printed the menus, gave them to nursing so that nursing could take the menus to residents to let them make their menu choices. The DM stated that sometimes nursing staff collected and returned the resident select menus and sometimes dietary staff had to go get them, especially on the weekends. He stated that if nursing did not return the select menus, dietary had to go to residents and ask them what they wanted to eat. The DM further stated that since he implemented this system in March 2022, there were still a few residents who said they still did not get to select their menus, especially on the weekend.

An interview with the Interim Director of Nursing (IDON) on 04/12/22 at 1:18 PM revealed she started in this role in March 2022, and she was aware that residents have stated they did not consistently get a menu to select their choices. She stated that when this concern was brought to management attention, the plan was to have

F 565

had been mentioned during previous months meetings (2/2022, 3/2022).
Administrator provided education to leadership team on 5/4/2022 noting response to concerns voiced in resident council meetings was mandatory.
Activities director was educated on Activities Policies and Procedures Policy #601, which states she is to provide the administrator with the original minutes of the Council Meetings along with Administrative response to the Resident Council form for review and signature.
Administrator will meet weekly with the Resident Council Current President weekly x4 weeks, biweekly x4 weeks, then monthly x3 months with monthly review of original minutes of meeting along with the administrative response to resident council.
How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:
The results of the audits will be reviewed at the QAPI committee for analysis of any patterns, trends, or need for further systemic changes.

Date of Completion 05/16/2022.

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F 565	Continued From page 6 dietary staff bring the menus to nursing, an assigned nurse aide would take the menus to residents and return the completed menus to dietary. The IDON further stated that this concern continued to come up a few times during morning management meetings, as unresolved since some residents expressed it was still a problem. The Administrator was interviewed on 04/12/22 at 04:52 PM and stated that the resident concern regarding not getting their menus was brought up during RC, but a plan was put in place and this plan was documented as follow up on the March 2022 RC meeting minutes. The Administrator stated this plan was discussed during morning management meetings and dietary stated that a couple of residents still expressed this was not resolved but that most residents expressed that this concern had improved. The Administrator further stated that he was not aware that residents still had concerns will not getting their menus. The Administrator stated that he expected resolution to this concern with the plan that was put into place. The Administrator stated that he and the DM were responsible for monitoring the plan.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		5/16/22

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F 578	Continued From page 7 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to determine, on admission, if 1 of 3 sampled residents had an advance directive (Resident #77) and failed to develop a care plan for advanced directives for 1 of 3 sampled residents reviewed for advanced directives	F 578	F578 How Corrective Action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 578

Continued From page 8

(Resident #70).

The findings included:

1. Resident #77 was admitted on 3/25/22 from the hospital.

An admission Minimum Data Set assessment dated 3/28/22 assessed Resident #77 with no speech or spoken words, rarely able to understand or be understood and severely impaired cognition.

A hospital discharge summary, dated 3/25/22, a progress note dated 3/30/22 by the Discharge Planner and a care plan, revised 4/4/22 revealed no advanced directive was documented. The progress note, written by the Discharge Planner dated 3/30/22 documented Resident #77 did not have an advance directive indicated.

The medical record for Resident #77 did not document an advance directive until 4/11/22, 16 days after admission.

An interview on 04/12/22 at 6:33 PM with the Discharge Planner revealed when he completed the social services assessment for Resident #77 on 3/30/22, he did not see advanced directives documented in the medical record. He stated this information was to be obtained by nursing and input in the medical record.

An interview on 04/13/22 at 11:27 AM with Nurse #3 revealed she processed the admission for Resident #77. Nurse #3 stated that when a resident was admitted from the hospital, the nurse was responsible to review the hospital records for advanced directives and to provide

F 578

Resident #77s code status was entered into medical record on 04/11/2022. Resident #77s care plan was updated 05/03/2022 to reflect code status and advance directives. Resident #70 is no longer a resident at the facility.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

Current residents have the potential to be affected by the alleged deficient practice. Current residents had advanced directives audited for compliance on 05/03/2022 to ensure that all had code status entered into electronic medical records.

Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
Licensed nurses will be in-serviced that upon admission and readmission residents will have their medical records reviewed for advanced directive documentation (code status), if no advanced directive (code status) is identified the admission nurse/licensed nurse will obtain the code status, and obtain an order and enter into electronic medical record. Any Licensed Nurse who has not received education by 05/16/2022 will not be allowed to work until received education
New hired licensed nurses will be educated in general orientation on obtaining a code status, advanced directive on admission or readmission. Minimum Data Set Nurses will be

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F 578	Continued From page 9 this documentation to medical records to be included in the electronic medical record. Nurse #3 stated if advance directives was not in the hospital records, the nurse should ask the resident, or responsible party (RP), to provide or clarify and relay this to the manager. Nurse #3 stated she could not recall if she reported to the manager that Resident #77 did not have advanced directives indicated in the hospital records or if she contacted the RP to clarify. An interview with the Interim Director of Nursing (IDON) occurred on 04/13/22 at 12:45 PM. The IDON stated that the admitting nurse should capture the code status from the admission packet, on admission, and if not documented, the nurse should talk to the resident or the RP and enter the code status into the medical record during the admission processes. A telephone interview with the Regional Nurse Consultant occurred on 4/13/22 at 12:50 PM and revealed a resident's advance directive should be completed as part of the admission process and documented in the medical record. 2. Resident #70 admitted to the facility on 1/10/2020. A review of a Significant Change Minimum Data Set Assessment dated 3/18/2022 completed for Resident #70 revealed he was cognitively intact. Resident #70's Care Plan with a revision date of 4/1/2022 was reviewed and there was not a care plan in place for Resident #70's advanced directives. A medical record review revealed Resident #70	F 578	educated to enter care plan for code status and advanced directives if any for admissions and readmissions. How facility plans to monitor its performance to make sure that solutions are sustained: Director of Nursing, Unit Managers, medical records coordinator and/or assigned designee will conduct audits on new and readmit admissions 5x per week x 4 weeks, 2x per week x4 weeks, 1x per week x 4 weeks, then monthly x2. Results of audits will be reviewed at Quarterly Quality Assurance Risk meeting X 2 for further problem resolution if needed. Completion Date 05/16/2022	

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F 578	Continued From page 10 had advanced directives and his Do Not Resuscitate form was dated 8/19/2021. During an interview with the Director of Nursing on 4/13/2022 at 3:07 pm she stated she was the Minimum Data Set (MDS) Nurse and the interim Director of Nursing. She stated advanced directives are not care planned by the facility and it is a company policy. She stated the facility does put a copy of the resident's advanced directives in a book at the nurse's station and they upload the advanced directives into the electronic record. An interview was conducted with the Administrator on 4/13/2022 at 5:04 pm and he stated the facility does not include the advanced directives in the resident's care plan. The Administrator stated the facility was in the process of reviewing the regulations regarding advanced directives to see if they need to include the advanced directives in the care plan.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		5/16/22

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F 580	Continued From page 11 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and legal guardian interview the facility failed to notify a resident's legal guardian of a hospital	F 580	F580 How corrective action will be accomplished for those residents found to	

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F 580 Continued From page 12

admission for 1 of 1 resident reviewed for notification of changes (Resident #76).

Findings included:

Resident #76 was admitted to the facility on 8/17/18.

A progress note written by Nurse #12 on 3/14/22 read "this writer contacted on call, awaiting triage to call for further instruction."

A progress note dated 3/19/22 revealed Resident #76 had arrived back to the facility. There was no additional documentation showing the guardian was contacted.

A phone interview was completed with Resident #76's guardian on 4/11/22 at 9:14 PM who stated she became aware of Residents #76 admission to the hospital on 3/16/22 from the hospital needing some additional information from the guardian. The guardian stated that she had not received a voicemail or any phone call from the facility. The guardian stated she had called the facility on 3/16/22 requesting to speak to the Interim Director of Nursing but was unable to reach her.

A telephone interview was completed with Nurse #12 on 4/12/22 at 10:35 AM who stated that she was the one working with Resident #76 on 3/14/22 and notified the physician and stated she did notify the responsible party and left a message. Nurse #12 stated she had filled out a E-interact transfer form (A form used as communication for SBAR; situation, background, assessment, and recommendation) which would have the emergency contact information. Nurse

F 580

have been affected by the deficient practice.
Resident #76□s guardian was notified of hospital transfers the patient has sustained over the previous 3 months.
How the facility will identify other residents having the potential to be affected by the deficient practice.
Current residents have the potential to be affected by the alleged deficient practice. An audit was conducted, by the interdisciplinary team, of resident charts progress notes from 04-10-2022 through 05/03/2022 on 05/04/2022 to identify any residents without notification to guardian or responsible party of a hospital transfer, with immediate corrections as indicated.
The measures put into place or systemic changes made to ensure that the deficient practice will not recur.
Licensed nursing staff will receive education from the Director of Nursing or designee on the requirement and process of notifying the guardian or responsible party of a hospital transfer; completed by 05/16/2022.The Director of Nursing and Unit Managers will review the daily progress notes to verify guardian and responsible parties are notified of hospital transfers 5 times per week for 4 weeks, 2 times per week for 4 weeks, and 1 time per week for 4 weeks.
How facility will monitor corrective action to ensure deficient practice will not re-occur:
The results of the audits will be reviewed with QAPI committee for further education or systemic changes as needed. Any staff member found to be non-compliant with

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F 580	Continued From page 13 #12 stated that if there was not a note in the record then she had not put one in the record, but a note was supposed to be put in the record. A review of the E-interact form was reviewed, and name of family/health care agent notified was blank for the name, date and time but was signed below by Nurse #12. An interview was completed with the interim Director of Nursing (DON) on 4/12/22 at 2:25 PM who stated that if the resident had a guardian, the nurse would leave a message for them regarding the notification of change in condition. An interview was completed with the Administrator on 4/12/22 at 5:15 PM who stated that he would expect that staff notify the responsible party or guardian if a resident is sent to the hospital.	F 580	the requirements to notify the physician will be disciplined using the progressive discipline process. Date of completion: 5/16/2022	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information	F 636		5/16/22

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(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section,

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F 636	Continued From page 15 "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an admission Minimum Data Set (MDS) assessment (Resident #235) within the required time frames for 1 of 3 comprehensive MDS assessments reviewed. Findings Included: Resident #235 was admitted to the facility on 3/23/22. Review of Resident #235's admission Minimum Data Set (MDS) revealed the assessment reference date (ARD) was 4/5/22. The assessment was not complete and revealed a status of 'in progress' as of 4/12/22. An interview was completed on 4/12/22 at 2:33 PM with the Interim Director of Nursing (DON) and former MDS Coordinator who stated that Resident #235's admission MDS assessment was in progress, and it was due on 4/5/22 and was late. The interim DON stated that she had been doing both jobs by herself, both the MDS Coordinator job duties and the DON duties as the reason for being late. The interim DON stated that she had been training a nurse to learn the MDS job responsibilities. An interview was completed with the Administrator on 4/13/22 at 7:22 PM who stated that his expectation is that the MDS assessments are to be done as soon as possible and to be	F 636	F636 How corrective action will be accomplished for each resident found to be affected by the deficient practice. No action taken as resident is no longer a resident in the center. How the corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice Current residents with an OBRA MDS in progress with an ARD prior to May 16, 2022 will be completed timely per RAI Guidelines by Date of Compliance of May 16, 2022. Measures to be put in place or systemic changes made to ensure practice will not re-occur Minimum Data Set Coordinators were educated by the Regional Director of MDS/designee on the timely completion of OBRA Minimum Data Set by the guidelines for timely completion of Minimum Data Set from RAI Manual by Minimum Data Set Consultant on May 5, 2022. Regional Minimum Data Set Nurse/ designee will audit 5 Minimum Data Set for timely completion weekly for 4 weeks, biweekly for 8 weeks, and then monthly times two months beginning May 16, 2022. The results of the audits will be reviewed	

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F 636	Continued From page 16 timely.	F 636	at the QAPI committee for analysis of any patterns, trends, or need for further systemic changes during Quarterly Quality Assurance meeting x2 for further resolution if needed. Completion May 16, 2022	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 655		5/16/22

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F 655	Continued From page 17 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and implement a baseline care plan for 1 of 3 residents, Resident #83, reviewed for care plans initiated within 48 hours of admission. Findings included: Resident #83 admitted to the facility on 3/1/2022 with diagnoses of stroke and communication deficits. She discharged from the facility on 3/4/2022. A review of Resident #83's electronic record revealed there was not a care plan in her record. An interview was conducted with the Director of Nursing (DON) on 4/12/2022 at 3:57 pm. The DON stated she did not see a care plan for Resident #83 in the electronic system. She stated if the baseline care plan was completed when Resident #83 was admitted it would be in the electronic record so it must not have been	F 655	F 655 Baseline Care Plan How corrective action will be accomplished for each resident found to have ben affected by the deficient practice. Resident #83 is no longer a resident of the facility. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice An audit of residents who were admitted to the facility during the past 30 days will be completed in order to ensure that each resident has an appropriate and up to date base line care plan in place. Measures to be put in place or systemic changes made to ensure practice will not re-occur. The Director of Nursing or designee will provide education to licensed nurses on the requirements for Baseline Care Plan completion. This education included the	

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F 655	Continued From page 18 completed. The DON further stated the baseline care plan should be completed within 48 hours of admission. During an interview with the Admission Nurse on 4/13/2022 she stated the baseline care plans are in the electronic record under the care plan tab. She further stated it did not look like Resident #83 had a baseline care plan because there were no care plans in the electronic record for Resident #83. The Admission Nurse stated if she does the an admission she completed the baseline care plan while she is doing the admission, but she did not do Resident #83's admission. On 4/13/2022 at 5:04 pm the Administrator stated the nurse who is responsible for a resident on admission should do the baseline care plan when they are admitted. The Administrator also stated the facility plans to re-educate the nurses regarding what is expected when a resident is admitted to the facility.	F 655	importance of ensuring that all residents have a Baseline Care Plan implemented within the first 48 hours after admission to the facility. The Baseline Care Plan must include the minimum healthcare information necessary to properly care for a resident including, but not limited to following: " Initial goals based on admission orders " Physician orders Dietary orders " Therapy services " Social services needs " PASARR recommendation, if applicable. The educational material included the fact that the care plan is a tool used to communicate residents condition, needs, preferences, strengths, special needs to the interdisciplinary team and primarily frontline staff, and that in order to provide the highest quality of care possible and to ensure residents needs are met, the care plans must be person-centered and an accurate and current reflection of resident s condition and needs. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. How the facility will monitor corrective action to ensure deficient practice will not re-occur Director of nursing or designee will audit new admission care plans for completion 5x per week x 4 weeks, 2x per week x4 weeks, 1x per week x 4 weeks, then monthly x2. Results of audits will be reviewed at Quarterly Quality Assurance Risk meeting X 2 for further problem resolution if needed.	

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F 655	Continued From page 19	F 655	Date of completion: 05/16/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to invite a resident to participate in the development and revision of their care plan for 1 of 8 residents reviewed for care plan meetings (Resident # 20).	F 657	F657 How corrective action will be accomplished for each resident found to have been affected by the deficient	5/16/22

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F 657

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Findings Included:

Resident #20 was admitted to the facility on 10/8/19 with a diagnosis including end stage renal disease.

Resident #20's quarterly Minimum Data Set assessment dated 2/2/22 revealed the resident was assessed as cognitively intact.

An interview was conducted on 4/10/22 at 2:46 PM with Resident #20 who stated that he never knows when he is having a care plan meeting, had not received an invitation, and had not attended his care plan meetings.

A record review revealed care plan invitations were sent to the resident's responsible party for 8/12/21, 11/17/21, and 2/21/22.

An interview was completed with the with the Interim Director of Nursing (DON) who was the former MDS Coordinator on 4/12/22 at 2:11 PM who stated the MDS coordinator was responsible for sending out the care plan invitations. The interim DON stated that Resident #20's care plan invitation would be sent to the responsible party and would not include Resident #20 because he had a responsible party. The interim DON stated even though a resident may be alert and oriented, if they have a responsible party then the responsible party is included for the care plan but not the resident. The Interim DON stated that she would go by who is the residents own responsible party and not on whether they are assessed as being cognitively intact, but most of the residents who are alert and oriented are responsible for themselves and therefore would

F 657

practice
Facility failed to invite a resident #20 to participate in the development and revision of their care plan by attending the care plan meeting. Resident #20's Quarterly Minimum Data Set dated 2/2/22 revealed the resident was not invite to participate in his care plan meeting.
Resident #20 care plan invitation only included the resident□s responsible party to attend the care plan meeting on 2/24/22.
Resident # 20 and their Responsible Party were invited to a care plan meeting on 5/5/22.
How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice
Current residents have the potential to be affected by the alleged deficient practice.
Current residents with an OBRA MDS scheduled will be invited to participate in the development and revision of their care plan by attending the care plan meeting starting 5/5/2022.
Measures to be put in place or systemic changes made to ensure practice will not re-occur:
Minimum Data Set Coordinators were educated on the RAI Guidelines for a resident to participate in the development and revision of their care plan by attending the care plan meeting.
Regional Minimum Data Set Nurse/ designee will audit 5 Minimum Data Set for resident□s participation in the development and revision of their care plan weekly for 4 weeks, biweekly for 8

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F 657	Continued From page 21 get an invite, but Resident #20 did have a responsible party and therefore they would not include Resident #20 in the care plan meeting. The interim DON stated that some families would have the resident attend the care plan meeting if the family wanted to have the resident participate and stated that Resident #20's responsible party had not attended the care plan meetings. An interview was completed with the Administrator on 4/13/22 at 7:24 PM who stated that his expectation is that residents should be involved in their care plan.	F 657	weeks, and then monthly times two weekly Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. Completion May 16, 2022	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F 732		5/16/22

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(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, the facility failed to record the resident census for 3 of 6 days reviewed (1/5/22, 1/6/22, and 1/7/22), record nurse staffing data for 1 of 6 days reviewed (1/16/22) and record accurately licensed and unlicensed nursing staff on the Daily Nurse Staffing Summary for 4 of 6 days reviewed (1/3/22, 1/5/22, 1/6/22, and 1/7/22).

The findings included:

A review of the Daily Nurse Staffing Summary for 1/3/22, 1/5/22, 1/6/22, 1/7/22, 1/16/22, and 1/20/22 revealed the following:

1. The resident census was not recorded per shift on 3 of 6 days reviewed; 1/5/22, 1/6/22, and 1/7/22.

The staffing scheduler was interviewed on 4/13/22 at 6:01 PM and stated she started training in her role on 1/20/22 and was responsible for posting the nurse staffing data in

F 732

F732

How corrective action will be accomplished for those residents found to have been affected:
Nursing staffing sheets were corrected for the dates found to be incorrect: 1/3/22, 1/5/22, 1/6/22, 1/7/22, 1/16/22, 1/20/22.

How the facility will identify other residents having the potential to be affected by the same deficient practice:
Current residents have the potential to be affected. Director of Nursing or designee will audit last 2 weeks of staffing sheets to ensure all corrections have been made as the result of staffing changes such as call outs.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

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F 732	Continued From page 23 lobby area. She reviewed the nurse staffing records and stated that the nurse staffing data should have been recorded correctly. An interview with the Administrator on 4/13/22 at 6:36 PM revealed he expected the nurse staffing data to be posting daily with the current census and should accurately reflect the staffing in the facility. 2. There was no record of the Daily Nurse Staffing Summary for 1/16/22. The staffing scheduler was interviewed on 4/13/22 at 6:01 PM and stated she started training in her role on 1/20/22 and was responsible for posting the nurse staffing data in lobby area. She reviewed the nurse staffing records and stated that the nurse staffing data should be posted. An interview with the Administrator on 4/13/22 at 6:36 PM revealed he expected the nurse staffing data to be posting daily with the current census and should accurately reflect the staffing in the facility. 3. The Daily Nurse Staffing Summary was not recorded accurately for licensed and unlicensed nursing staff for the following: ·1/3/22, 7 AM to 3 PM shift recorded 15 nurse aides (NA); staffing assignment sheets recorded 10 NA had worked. ·1/3/22, 3 PM to 11 PM shift recorded 6 NA; staffing assignment sheets recorded 7.5 NA had worked. ·1/5/22, 7 AM to 3 PM shift recorded 2 Registered	F 732	The scheduler and service ambassadors were educated by the Director of Nursing or designee on ensuring the staffing hours information is filled out on the daily staffing sheet each day with corrections following staffing changes. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing or designee will audit the daily staffing sheet for staffing hours 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 months Findings from audits will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. The administrator is responsible for implementing the acceptable plan of correction Date of Completion: 5/16/2022	

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F 732	Continued From page 24 Nurses (RN), and 8 NA; staffing assignment sheets recorded 1 RN and 10 NA had worked. ·1/5/22, 3 PM to 11 PM shift recorded 7 NA; staffing assignment sheets recorded 5 NA had worked. ·1/6/22, 7 AM to 3 PM shift recorded .5 RN, 3.5 Licensed Practical Nurses (LPN), and 16 NA; staffing assignment sheets recorded 1 RN, 4 LPN, and 10 NA had worked. ·1/6/22, 3 PM to 11 PM shift recorded 1.5 LPN and 5 NA; staffing assignment sheets recorded 3.5 LPN and 7 NA had worked. ·1/6/22, 11 PM to 7 AM shift recorded 3 LPN and 7 NA; staff assignment data recorded 2 LPN and 8 NA had worked. ·1/7/22, 3 PM to 11 PM shift recorded 7 NA; staffing assignment sheets recorded 8 NA had worked. ·1/7/22, 11 PM to 7 AM shift recorded 2 LPN; staffing assignment sheets recorded 3 LPN had worked. The staffing scheduler was interviewed on 4/13/22 at 6:01 PM and stated she started training in her role on 1/20/22 and was responsible for posting the nurse staffing data in lobby area. She reviewed the nurse staffing records and stated that the nurse staffing data should have been recorded correctly. An interview with the Administrator on 4/13/22 at 6:36 PM revealed he expected the nurse staffing data to be posting daily with the current census and should accurately reflect the staffing in the facility.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		5/16/22

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F 761	Continued From page 25 §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 record review, observations and staff interviews the facility failed to remove expired medications from 2 of 2 medication carts (100 hall and 200 hall); failed to remove expired medications from 1 of 2 medication storage rooms (200 hall); and failed to date and refrigerate a probiotic after opening in 1 of 2 medication carts (200 hall). The findings included: 1. An observation (Nurse #1 present during	F 761	F761 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Expired medications were immediately removed from the medication carts and discarded. The medication which was not refrigerated, was discarded and a new bottle ordered from the Pharmacy.	

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F 761	Continued From page 26 observation) on 4/13/22 at 9:00 AM of the medication cart for the 100-hall revealed Nitroglycerine tablets expired (EXP) 2/20/22. An interview with Nurse #1 (100 hall) 4/13/22 at 9:00 AM revealed she mistakenly overlooked the expired medication. Nurse #1 further revealed she usually reviews the medication cart for expired medications each shift she works. 2. An observation on 4/13/22 at 9:27 AM of the medication cart for the 200-hall revealed: - Vitamin C tablets EXP 2/22 - Calcium 600 mg Vitamin D tablets EXP 9/21 - Multivitamin One Daily tablets EXP 3/22 - Ferrex CAPS EXP 3/22 3. An observation on 4/13/22 at 9:45 AM revealed Acidophilus probiotic 1 billion 100 CAPS; 26 CAPS remaining; label directions indicated store at room temperature and refrigerate after opening (no date when opened). 4. An observation on 4/13/22 at 9:50 AM of the medication storage room for the 200-hall revealed: - Adult Aspirin, unopened EXP 2/22 - Antiseptic Wound & Skin Cleanser EXP 7/20 An interview with Nurse #2 (200 hall) on 4/13/22 at 9:27 AM revealed she was returning from days off and was unaware of the expired medications. She further revealed each shift nurse should review the cart for expired medications and remove them. Nurse #2 also indicated she was unaware of who was responsible for reviewing the medication storage room for expired medications. An interview with the Administrator on 4/12/22 at	F 761	How facility will identify other resident having the potential to be affected by the same deficient practice. Current residents have the potential to be affected by the alleged deficient practice. Unit managers and Regional Director of Clinical Services conducted audits of current medication storage rooms, medication rooms, and med carts to ensure expired medications were discarded. Measures to be put in place or systemic changes made to ensure practice will not re-occur: The DON or designee to provided facility licensed nurses with education noting medications must be labeled and stored according to manufacturer□s guidelines. Undated and expired medications are to be discarded immediately form medication carts, med storage rooms, and refrigerators and medications requiring refrigeration must be dated with open date and stored in the refrigerator How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: DON, Nursing administration will conduct reviews of medications in the facility storage rooms, medication rooms, and medication carts for expired medications 3 times a week for 4 weeks, 1 time a week x 8 weeks, and then monthly x 2 months. The facility pharmacist will also review medications carts monthly and report any concerns with labeling and storage of drugs to the Administrator and Director of Nursing.	

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F 761	Continued From page 27 4:48 PM revealed each shift nurse is responsible for reviewing the cart and medication storage room for expired medications and removing them.	F 761	The results of the audits will be reviewed at the QAPI committee for analysis of any patterns, trends, or need for further systemic changes. Date of Completion 5/16/2022	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident interviews, and staff interviews, the facility failed to provide meals that were palatable and at an appetizing temperature to 2 of 2 sample residents (Resident #283 and #35). The findings included: a. Resident #283 was admitted to the facility on 3/28/22. An Admission Minimum Data Set (MDS) assessment dated 2/27/22, assessed Resident #283 with clear speech, adequate hearing/ vision, able to understand and be understood, intact cognition and independent with eating after tray set up. On 4/10/22 at 5:42 PM Resident #283 was observed during his dinner meal, attempting to	F 804	F804 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #283 is no longer a resident at the facility. Resident #35 is now receiving his food preferences as well as his food being palatable and served at the correct temperatures. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice Current residents have the potential to be affected by the alleged deficient practice	5/16/22

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F 804

Continued From page 28

eat a pork steak with his fork. He stated the potatoes were hard and meat was inedible to a point he had a hard time getting a fork through them.

b. Resident #35 was readmitted to the facility on 12/23/21. An annual MDS assessment dated 2/9/22 indicated Resident #35 was cognitively intact and required extensive one-person assistance with bed mobility, speech was clear, hearing/ vision was adequate, and she was independent with eating, able to understand and be understood.

On 4/11/22 at 9:55 AM Resident #35 indicated lunch and dinner are "horrible" meals and she cannot eat them at times.

A test tray was requested on 4/13/22 at 5:40 PM for a regular dinner meal tray. The meal was plated at 5:44 PM with French fries, mashed potatoes, cubed steak, carrots, and chicken strips. The Registered Dietician (RD) left the kitchen at 5:46 PM with the test tray and arrived on the 200 Hall at 5:48 PM. All residents on the 200 Hall were served 5:58 PM and the test tray was sampled. Margarine and salt were added to the hot foods and the margarine remained congealed. The RD and surveyor sampled the foods and observed the following: the chicken strips were without visible steam, while the cubed steak and mashed potatoes were room temperature. The RD stated the chicken strips and French fries were "a little dry and slightly warm." She further stated the cubed steak and carrots had a good flavor and were slightly warm.

An interview with the Dietary Manager (DM) on 4/12/22 at 1:05 PM revealed he was aware of

F 804

Measures to be put in place or systemic changes made to ensure practice will not re-occur:
Administrator to educate current full time, part time, and as needed dietary staff and nursing staff on the expectation of serving foods that are palatable and at the resident□s preferred temperature. Education also to include the expectation of reheating a meal that was at an undesired temperature as well as offering an alternate to residents. Education will be added to new hire orientation.
How facility will monitor corrective actions to ensure deficient practice will not re-occur
The Dietary Service Director or designee will complete a test tray 5 x a week x 4 weeks, 3 x a week x 4 weeks, and 1x per week x 4 weeks, using the Dietary QA Audit. In addition, the Dietary Services Director will interview 5 residents weekly to ensure food preferences are being honored.
Results of audits will be reviewed in Quarterly Quality Assurance meeting x1.

Date of completion: 5/16/2022

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F 804	Continued From page 29 resident concerns about the chicken and baked French fries being too dry, as well as the fish being distasteful. The DM further revealed since the French fries are baked, it is harder to keep the temperature and they won't taste as good. An interview with the Administrator on 4/12/22 at 4:55 PM indicated he was aware of resident concerns about food and that the facility was not allowed to have a fryer to fry foods like chicken and French fries. The Administrator further indicated he plans to discuss plans with management and residents to have fast food orders delivered monthly.	F 804		
F 806 SS=E	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews, and record reviews, the facility failed to provide menu choices for 2 of 2 sampled residents (Resident #283 and #67). The findings included: 1a. Resident #283 was admitted to the facility on 3/28/22. An admission Minimum Data Set (MDS)	F 806	F806 How corrective action will be accomplished for those residents found to have been affected: Resident #283 and #67 are no longer a resident in the center.	5/16/22

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F 806	Continued From page 30 assessment, dated 2/27/22, assessed Resident #283 with clear speech, adequate hearing/vision, able to understand and be understood, intact cognition and independent with eating after tray set up. On 04/10/22 at 5:42 PM, Resident #283 was observed with his dinner meal. Resident #283 stated the foods he received were not what he wanted. He stated that residents were supposed to get a menu each day to make menu selections from and when he did not get a menu, "the dietary staff just sent you anything." He stated this had occurred four times already that week. He stated that when he asked nursing staff for his menu he was told, they could not deliver a menu to him if the menus were not provided from dietary. On 4/12/22 at 1:36 PM, Resident #283 indicated he ordered cubed steak and gravy but received meatballs for lunch. 1b. Resident #67 was admitted to the facility on 3/9/22. An admission MDS assessment, dated 3/15/22, assessed Resident #67 with clear speech, adequate hearing/vision, able to understand and be understood, moderately impaired cognition and independent with eating after tray set up. Resident #67 was observed with his dinner meal on 4/10/22 at 5:50 PM. He stated during the observation that he had not been able to make menu choices for a while now. He stated that he used to get a menu to select the foods he wanted, he asked about the menu, but still did not get a menu, so now, he just ate whatever he got. The Dietary Manager (DM) was interviewed on 04/12/22 at 1:05 PM and stated he was the DM since 3/3/22. He stated that he was made aware that before he started, residents voiced concerns	F 806	How the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected by the alleged deficient practice. Measures will be put into place or systemic changes made to ensure that the deficient practice will not re-occur: Administrator will educate dietary staff to put each resident�s meal ticket for the next day�s meal options on the lunch tray of the resident and nursing will complete and place back on the resident�s tray to have it returned to the kitchen. Dietary staff will be responsible for the retrieval of the meal tickets from the returned tray. Nursing staff will be educated the tickets are coming on the lunch tray, they are to complete, and return to the tray for ticket to be returned to the kitchen. Education will be completed by 05/06/2022. Dietary Manager or designee will audit 20% of meal trays for accuracy 5 weekly x 4 weeks, 3 times a week x 4 weeks, weekly x 4 weeks, then monthly X 1 to ensure compliance with accuracy. Any deficient practice identified through the tray accuracy evaluation will result in progressive disciplinary action as indicated. All new hires will receive in-service education during orientation on proper procedures for ensuring menu adequacy to honor food preferences. Indicate how the facility plans to monitor its performance to make sure that	

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F 806	Continued From page 31 during Resident Council that they did not like the menu selection system in place so now he printed the menus, gave them to nursing so that nursing could take the menus to residents to let them make their menu choices. The DM stated that sometimes nursing staff collected and returned the resident select menus and sometimes dietary staff had to go get them, especially on the weekends. He stated that if nursing did not return the select menus, dietary had to go to residents and ask them what they wanted to eat. He stated that on weekends he typically had 2 dietary staff to prepare and deliver foods and this did not allow time for dietary staff to go to residents and ask them what they wanted to eat. He stated that as a result, there were still a few residents who said they still did not get to select their menus, especially on the weekend. An interview with NA #3 on 4/12/22 at 4:17 PM indicated Resident #283 did not receive a menu on multiple occasions and received random food items he would not have ordered if he had completed a menu. An interview with the Interim Director of Nursing (IDON) on 4/12/22 at 1:18 PM revealed she was aware that residents reported they did not consistently get a menu to select their choices. She further revealed as a result, management implemented a plan to have dietary staff bring the menus to nursing and an assigned NA would take the menus to residents and return the completed menus to dietary. The IDON stated this concern continued to come up a few times during morning management meetings, since some residents expressed it was still a problem. An interview with the Administrator on 4/12/22 at	F 806	solutions are sustained Results of audits will be reviewed in Quarterly Quality Assurance meetings x2 for further problem resolution if needed. Date of Completion: 5/16/202	

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F 806	Continued From page 32 4:52 PM revealed resident concerns regarding not receiving their menus was discussed during Resident Council and a plan was put in place per minutes from March 2022 Resident Council Meeting. The Administrator further indicated the plan was also discussed during morning management meetings, whereas dietary reported a couple of residents continued to report the issue was unresolved but that most residents reported the process had improved. The Administrator expressed he and the DM were responsible for monitoring the plan.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources 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, record review, and staff interviews, the facility failed to discard food	F 812	F812	5/16/22

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F 812	Continued From page 33 products (boiled eggs, raw shredded cabbage, and shredded cheese) on or before the expiration date and hold French fries at least 135 degrees Fahrenheit on the steam table. This had the potential to affect 22 of 86 residents. The findings included: 1a. An observation with the Dietary Manager (DM) of the walk-in refrigerator occurred on 4/10/22 at 3:40 PM with the following concerns identified: -A box of boiled eggs, with 6 unopened packages, of 12 eggs per package, recorded a manufacture's expiration date of 3/22/22. -An unopened bag of shredded cabbage with a manufacture's expiration date of 3/22/22. An interview with the DM on 4/10/22 at 3:30 PM revealed he began working at the facility on 3/3/22. He stated that refrigerated food items should have a label with 2 dates, the date opened and the "use by" date. He further revealed he was not aware that there were expired foods in the refrigerator and no one person was assigned to check the expiration date on refrigerated foods. An interview with Cook #1 and Cook #2 on 4/13/22 at 7:15 PM revealed one package of boiled eggs was taken out of the refrigerator every morning for breakfast and any unused boiled eggs from the package were discarded. They further revealed no one person was assigned to check refrigeration for expired foods. 1b. An observation with the Regional Dietary Manager (RDM) of the walk-in refrigerator on the follow-up visit to the kitchen began on 4/13/22 at 10:55 AM with the following concerns identified:	F 812	How corrective action will be accomplished for those residents found to have been affected: Expired foods were immediately discarded. How the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents have the potential to be affected by the alleged deficient practice. Measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Current Dining Services employees will be in-serviced by the Registered Dietician/designee regarding proper procedures for discarding expired food items, labeling and dating item, storing food items when received, and proper procedure for storing foods in refrigerated/freezer storage. New hires will receive in-service education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained A sanitation inspection will be conducted by Corporate Registered Dietician or designee weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or	

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F 812	Continued From page 34 - There were 3 large plastic bags of parmesan cheese with a written "use by" date of 4/10/22 An interview with the Regional Director on 4/13/22 11:45 AM revealed he oversaw eleven food service accounts and acquired oversight of the facility food account last year. He visited the facility at least twice since October and usually performed sanitation audits, food tray audits and financial audits. He further revealed he was unaware there were expired foods in the refrigerator. He provided no explanation on why the parmesan cheese was not used or discarded by the "use by" date. 2. An observation of temperatures for dinner items on the steam table began on 4/11/22 at 5:03 PM with Cook #1 who obtained the food temperatures via a digital thermometer. She revealed the French fries had a holding temperature of 121 degrees Fahrenheit. An interview with Cook #1 on 4/11/22 at 5:30 PM indicated she prepared the French fries in the oven before placing them on the steam table. She further indicated the French fries were not prepared in a fryer and may lose their temperature when placed on the steam table. An interview with the DM on 4/11/22 at 5:45 PM revealed the French fries were usually baked in the oven for about 15 minutes before they were placed on the steam table, prior to serving. He further revealed hot foods should have a holding temperature of no less than 135 degrees Fahrenheit, to conserve nutritive value, flavor, appearance and texture. An interview with the Administrator on 4/12/22 at	F 812	disciplinary action as indicated. Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. Date of Completion: 05/16/2022	

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F 812	Continued From page 35 4:48 PM indicated he was not aware of the dietary process for food temperatures since the contracted food service provider handled the dietary contract.	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 record review and staff interviews the facility's Quality Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place following the complaint investigation survey of 12/01/2021. This was for the deficiency originally cited in December 2021 and subsequently recited on the current recertification and complaint survey of 04/14/2022 in Infection Prevention and Control (F880). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance (QA) Program. The findings included: This tag is cross-referenced to: F880 Infection Prevention and Control - Based on observation, record review, and staff interviews the facility failed to post an enhanced droplet precautions sign for 1 of 3 residents, Resident # 133,	F 867	F867 How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #133 has the enhance precautions signage posted on his room door. How the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents in the center who on isolation precautions have the potential to be affected. Measures put into place or systemic changes made to ensure that the deficient practice will not re-occur Administrator/designee will educate the facility QAPI (Quality Assurance and Performance Improvement) committee members on how to develop and implement appropriate plans of action to	5/16/22

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F 867	Continued From page 36 reviewed for quarantine when admitted after a hospitalization. During the complaint investigation survey of 12/01/2021, the facility failed to implement their infection control policy when a Nurse Aide (NA) failed to perform hand hygiene after handling soiled meal trays on the COVID-19 unit and prior to entering 3 resident rooms and when a NA failed to wear a N95 mask when entering a resident room with enhanced droplet precautions in place. The Administrator was interviewed on 4/13/22 at 5:52 PM. During the interview, he stated that the facility addressed the infection control concerns cited during the December 2021 complaint survey during the QAPI Committee monthly and quarterly meetings to maintain compliance, but that the current concerns with posting precaution signage was a new concern related to infection control that had not previously been identified by the facility.	F 867	correct identified quality deficiencies. The facility will implement Performance Improvement Plans based on the plan of correction for F-tag F880 and share the findings with the QAPI committee each month for 4 months. The QAPI committee will continue to use audits and data to determine areas below expectation and implement Performance Improvement Plans as indicated. How the facility plans to monitor its performance to make sure that solutions are sustained. Monthly QAPI committee minutes will be reviewed by Regional Director of Clinical Services for review and recommendations. Date of completion: 05/16/2022.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		5/16/22

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F 880	Continued From page 37	F 880		

a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 880	Continued From page 38 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to post an enhanced droplet precautions sign for 1 of 3 residents, Resident # 133, reviewed for quarantine when admitted after a hospitalization. The facility was not in outbreak status at the time of the survey. Finding included: Resident #133 admitted to the facility from the hospital on 4/8/2022 with a history of stroke. A review of Resident #133's immunization record revealed he had not received a vaccination for COVID 19. A Physician's Order dated 4/11/2022 stated Resident #133 should have Enhanced Droplet Precautions until 4/18/2022. An observation of Resident #133 on 4/10/2022 at 3:30 pm revealed he did not have an Enhanced Droplet Precautions sign on his door. The Enhanced Droplet Precautions sign was observed on Resident #133's door on 4/11/2022	F 880	F880 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #133 has the enhance precautions signage posted on his room door. How the facility will identify other residents having the potential to be affected by the same deficient practice. Current residents in the center who on isolation precautions have the potential to be affected. The measures put into place or systemic changes made to ensure that the deficient practice will not Director of Nursing or designee will educate current licensed nurses, including, admission nurse by 05/06/2022	

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F 880	Continued From page 39 at 11:33 am. During an interview with Nurse #1 on 4/13/2022 at 2:03 pm she stated she cared for Resident #133 on Sunday, 4/10/2022, and he did not have an Enhanced Droplet Precautions sign on his door when she worked. Nurse #1 stated the Admissions Nurse should place the Enhanced Droplet Precautions sign on a resident's door when they were admitted. Nurse #1 stated the Infection Preventionist would also place the Enhanced Droplet Precautions sign on residents that were from the hospital. Nurse #1 stated she had not been told to place the Enhanced Droplet Precautions sign on the door when the Infection Preventionist and the Admissions Nurse were not available. Nurse #1 stated Resident #133 had an Enhanced Droplet Precautions sign on his door when she came into work this morning. The Director of Nursing was interviewed on 4/13/2022 at 3:25 pm and stated the nurse assigned to a resident when they were admitted was responsible for ensuring the resident's immunization status was documented and if they have not been immunized for COVID 19 then Enhanced Droplet Precautions should be put into place and the nurse should place a sign on the door. An interview was conducted with the Admissions Nurse on 4/13/2022 at 2:33 pm and she stated she completed admission assessments when residents were admitted and the Infection Preventionist checks the resident's immunization status and then puts the Enhanced Droplet Precautions sign on their door if they have not been immunized for COVID 19. The Admission Nurse stated the nurse who was responsible for	F 880	on how to identify residents who need enhance precautions, to communicate it to Central Supply Coordinator for supplies, and where to find supplies if central supply coordinator is not present. Licensed nurses who do not receive the education will not be allowed to work after the completion date until education is provided. How the facility plans to monitor its performance to make sure that solutions are sustained. Infection preventionist or designee will complete audits of current/newly admitted residents to ensure enhanced precaution signage is hanging on the door with supplies when appropriate. Audits will be conducted 5x per week x 4 weeks, 3 times per week x 4 weeks, weekly x2 weeks, then monthly x2. Results of audits will be reviewed in Quarterly Quality Assurance Meeting x2 for further problem resolution if needed. Date of Completion: 05/16/2022	

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F 880	Continued From page 40	F 880		

the resident on admission should place the Enhanced Droplet Precautions sign on the door if the Admissions Nurse and Infection Preventionist were not available. The Admissions Nurse stated she did not admit Resident #133 to the facility and the Infection Preventionist was not available when Resident #133 was admitted.

The Infection Preventionist was interviewed on 4/13/2022 at 5:58 pm and stated she does check each admissions immunization status and places the Enhanced Precautions Sign on their door if they have not been immunized when she was in the facility. The Infection Preventionist further stated the nurse assigned to the resident was responsible for ensuring each resident's immunizations were checked and the Enhanced Droplet Precautions sign was placed on the door if the resident has not been immunized.

An interview was conducted with the Administrator on 4/13/2022 at 5:04 pm and he stated the Nurse that cared for Resident #133 on admission should have ensured his immunization status was checked and he was placed under Enhanced Droplet Precautions. The Administrator stated the Infection Preventionist does make sure the immunizations of each new admission are checked and helps with putting the Enhanced Droplet Precautions signs in place but the nurse on admission was responsible.