STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING ______ B. WING ______	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS REHABILITATION CENTER	**121 RACINE DRIVE WILMINGTON, NC 28403**

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E 000	Initial Comments An unannounced recertification survey was conducted on 10/30/23 through 11/02/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # JSU911.	E 000		
F 000	INITIAL COMMENTS An oncite annual recertification survey along with a complaint survey was conducted from 10/30/23 through 11/02/23. Event ID# JSU911. The following complaint intakes were investigated: NC00196760 NC00206115 NC00199991 NC00203308 NC00207307 NC00203769 NC00197537 NC00199352 4 out of 18 complaint allegations were found to have deficient practice. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (G)	F 000		
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	F 565		12/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/22/2023

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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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.
(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 record review and staff and resident interviews, the facility failed to resolve repeat grievances that were reported to the resident council meetings for 3 of 3 months that resident council meetings were held (June 2023, July 2023, and September 2023).

Findings included:

F 565

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction

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The June 21, 2023, meeting minutes recorded by the Activity Director indicated concerns were expressed with dietary. The Resident Council stated meals were up to an hour late, were cold when received, and the food was overcooked and hard to chew.

The June Grievance log listed no grievance dated 6/21/23 on behalf of the Resident Council related to the concerns expressed at the meeting regarding late meals, cold food and food that was overcooked and hard to chew.

The July 31, 2023, meeting minutes recorded by the Activity Director indicated concerns were expressed with dietary. The Resident Council indicated meals were up to an hour late and were cold when received. Meals were served on Styrofoam trays instead of proper dinnerware. The council requested to meet with the Dietary Manager as soon as possible.

The July Grievance log listed no grievance dated 7/31/23 on behalf of the Resident Council related to the concerns expressed at the meeting regarding late meals, cold food and meals served on Styrofoam.

The August 23, 2023, meeting minutes indicated the meeting was canceled by the facility.

The September 26, 2023, meeting minutes recorded by the Activity Director indicated concerns were expressed with dietary. The Resident Council stated meals had no regular schedule and were served very late. The Resident Council expressed that the Resident Council choice meal was of poor quality and meals were frequently served on Styrofoam trays

F 565

constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F565 The facility failed to resolve repeated grievances that were reported to the resident council meetings for 3 of 3 months that resident council meetings were held (June 2023- September 2023).

1. Corrective action for resident(s) affected by the alleged deficient practice: An additional Resident Council meeting was held on 11 /22/2023. Minutes were taken by the Activities Director. Grievances/concerns were addressed with the Administrator on 11/24/2023 and addressed on 11/24 /2023 resolution with the appropriate department managers following the facility’s grievance process for resolution.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
Beginning with the 11/22/2023 resident council meeting, grievances/concerns, as well as any ongoing grievances/concerns will be reviewed by the administrator and applicable department managers for timely resolution following the facility grievance process.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 11/21/2023, the Administrator

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F 565	Continued From page 3 and they did not like it. The September grievance log listed no grievance dated 9/26/23 filed on behalf of the Resident Council related to the concerns expressed at the meeting regarding late meals, poor overall food quality and meals served on Styrofoam trays. The October 18, 2023 meeting minutes indicated the meeting was postponed by the facility. A Resident Council meeting was conducted on 11/1/23 at 10:00 AM with a sample of 5 cognitively intact members of the Resident Council in attendance. The members revealed there was an issue with resolution of grievances regarding food service. The residents in the meeting expressed concern about the food including timeliness and overall quality of the food served. The residents stated they discussed these concerns regarding food in the Resident Council meetings repeatedly and nothing was done. Multiple members of the Resident Council explained for several months they had expressed a variety of concerns regarding food service and had not received a response or resolution to the concerns. The Resident Council president stated concerns regarding dietary service were discussed by the council with the Dietary Manager. The residents expressed that for a long time now the overall quality of the food was poor, and it frequently did not look or taste good. The residents stated they received lots of excuses why there were problems with the food, but ultimately nothing was done to change it. The residents stated breakfast was served as late as 9:30 AM, lunch as late as 2:00 PM and dinner as late as 8:00 PM. The residents indicated lunch was served at 2:00 PM and dinner at 8:00 PM on	F 565	educated the facility department heads on the following: •F565 requirements •The Administrator educated department heads on the grievance process and at the daily standup meeting on 11/21/2023 assigned responsibility for timely resolution of grievances. •Going forward, Administrator or Director of Nurses (in his absence) will continue to assign responsibility for resolving grievances the morning after the Resident Council meeting. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 12/14/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator will monitor compliance utilizing the F565 Quality Assurance Tool weekly for 4 weeks then monthly x 3 months or until resolved. The tool will monitor to ensure that grievances from resident council meetings are addressed following the grievance process and are in	

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F 565	Continued From page 4 10/30/23. The residents stated food was a huge concern, it felt like no one cared when the concerns discussed in Resident Council were not addressed and they were frustrated by this. An interview on 11/1/23 at 12:42 with the Administrator discussed the process for addressing concerns voiced during the resident council meetings. He stated he received the monthly Resident Council Meeting minutes, reviewed them, and initiated grievance forms for concerns expressed in the meetings. The grievance forms were then distributed to the appropriate department manager. Once addressed by the department manager, the forms were returned to the Administrator for his review and to generate a letter detailing the resolution of the grievance. The Administrator revealed he was aware of the food concerns and the timing of the meals expressed repeatedly at the Resident Council meetings. He stated he did not recall filing a formal grievance on behalf of the Resident Council for the concerns expressed at the meetings held in June, July, or September. The Administrator admitted a grievance should have been filed regarding the food concerns with follow-up completed. The Administrator revealed there had been changes in the department managers with the Dietary Manager and Activity Director new in their roles and the Social Worker recently left. These changes contributed to grievances not being filed and addressed. The Administrator stated he thought the Dietary Manager attended the Resident Council meetings to address the residents' food concerns. The Administrator stated there was no formal monitoring of the food issues in place and that each department manager was responsible for	F 565	compliance. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 12/15/2023	

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F 565	Continued From page 5 addressing the grievances reported during the resident council meetings. Interview with the Dietary Manager on 11/1/23 at 2:50 PM revealed she was aware of the issues with the overall food quality and the times for meal service delivery expressed by the Resident Council, but she had not attended a meeting to address the concerns with the residents. The Dietary Manager stated she had not done any root cause analysis of the problem regarding the food or the meal service times. The Dietary Manager stated there was no auditing in place for monitoring the concerns. A follow-up interview was conducted with the Administrator on 11/2/23 at 4:50 PM regarding the concerns expressed at the Resident Council meeting held on 11/1/23. The Administrator revealed he was responsible for ensuring grievances were addressed but acknowledged there had not been follow-up with the dietary issues expressed at the Resident Council meetings. The Administrator stated he tried to let the Dietary Manager grow in her role, develop leadership and accountability, and address the Resident Council concerns without a formal monitoring plan in place. The Administrator revealed there had been more concerns regarding food recently and he should have implemented measures to address the concerns expressed by the Resident Council members.	F 565		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 602		12/15/23

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F 602	Continued From page 6	F 602		

and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
This REQUIREMENT is not met as evidenced by:
Based on record review and the Administrator's interview, the facility failed to prevent a staff member from taking personal property from a resident's room (Resident #85) for 1 of 1 residents reviewed for misappropriation of property.

Findings included:

Resident #85 was admitted to the facility on 07/21/23 and discharged on 08/23/23. Admitting diagnoses included, in part, non-displaced fracture of left radius and fracture of nasal bones.

The Minimum Data Set admission assessment dated 07/28/23 revealed Resident #85 was cognitively intact. Resident #85's hearing and vision were adequate and he required limited assistance with one staff physical assistance with activities of daily living.

An initial allegation report dated 08/07/23 was completed by the Administrator. The incident type was misappropriation of property. The facility became aware of the misappropriation of Resident #85's missing wallet at 1:45 PM. A summary of the allegation revealed Resident #85 stated a man came in his room and the resident woke up to see he was going through his bedside drawer. Resident #85 asked the man to give him his call light, and shortly thereafter, he noticed his wallet missing. Resident was upset with having

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F602
1. Corrective action for resident(s) affected by the alleged deficient practice:
The deficiency occurred after an agency staff member NA #8 stole a wallet from (Resident #85) allegation report dated 08/07/23 was completed by the Administrator. NA #8 was asked to go to the Administrator's office and police were notified. NA #8 left the Administrator's office to use the men's room in the main lobby near the Administrator's office. The police arrived minutes later and NA #8 returned to the Administrator's office where an interview was conducted. NA #8 denied the theft and was asked to leave the facility. The officer and the Administrator interviewed Resident #85

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to cancel his credit cards. The report was sent to the state agency on 08/07/23 at 3:27 PM.

The investigation report was completed by the Administrator on 08/10/23 and submitted to the state agency at 4:09 PM. A summary of the allegation details revealed the following: Resident #85 was at the facility for short term rehabilitation from a fall and fracture. Resident #85 stated a tall man came in his room and he woke to find him going through his bedside table, he asked what he was doing. The aide stated he was looking for a cord. After the aide left, Resident #85 checked his drawer and his wallet was missing. He called the nurse and the nurse notified the Administrator. Review of the cameras identified Nursing Aide (NA) #8 entering Resident #85's room at 12:07 PM and departing the resident's room at 12:09 PM. NA #8 was asked to go to the Administrator's office and police were notified. NA #8 left the Administrator's office to use the men's room in the main lobby near the Administrator's office. The police arrived minutes later and NA #8 returned to the Administrator's office where an interview was conducted. NA #8 denied the theft and was asked to leave the facility. The officer and the Administrator interviewed Resident #85 and when they returned to the front lobby, they searched the men's room and found the toilet to be overflowing. Housekeeping was notified to unclog the toilet and were able to recover four credit cards, a driver's license, membership warehouse card, an insurance card, and boater's registration belonging to Resident #85. Resident #85 stated he had about $50.00 in cash in his wallet. Resident #85 canceled his credit cards. Adult Protective Services was notified and video footage and pictures of evidence were uploaded

F 602

and when they returned to the front lobby, they searched the men's room and found the toilet to be overflowing. Housekeeping was notified to unclog the toilet and were able to recover four credit cards, a driver's license, membership warehouse card, an insurance card, and boater's registration belonging to Resident #85. Protective Services was notified and video footage and pictures of evidence were uploaded to the police department evidence share site. The agency NA #8 was employed with was notified of the allegation and subsequent findings. After the investigation, witness (Resident #85) statement and review of cameras, and finding items discarded in the restroom, it was reasonable to conclude NA #8 stole Resident #85's wallet The facility provided the abuse policy to include misappropriation of property which was noted to have NA #8's signature to indicate it was reviewed and dated on 04/26/23 by NA #8.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:

All residents who reside in the facility have the potential to be affected. The accused aide was removed from the facility and appropriate authorities contacted on 8/07/2023.
On 8/ 07/2023 the Social Worker conducted resident interviews on alert and oriented residents to determine if other residents were missing items with no noted concerns.

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F 602	Continued From page 8 to the police department evidence share site. The agency NA #8 was employed with was notified of the allegation and subsequent findings. After the investigation, witness (Resident #85) statement and review of cameras, and finding items discarded in the restroom, it was reasonable to conclude NA #8 stole Resident #85's wallet. Review of the North Carolina Nurse Aide Registry for NA #8 revealed the staff member had no criminal record to speak of. He had a misdemeanor in 2001 for writing bad checks on 11/23/2001 and 12/23/2001. The facility provided the abuse policy to include misappropriation of property which was noted to have NA #8's signature to indicate it was reviewed and dated on 04/26/23 by NA #8. A phone interview was attempted with NA #8 on 10/31/23 at 4:35 PM. NA #8 did not return call. An interview was conducted with the Administrator on 11/01/23 at 2:57 PM. The Administrator stated NA #8 was assigned to the assisted living side of the facility. The Administrator stated NA #8 informed him that he was going over to the skilled nursing side to get a mechanical lift. The Administrator stated when he reviewed the cameras, he watched NA #8 go down the hall that Resident #85 resided on, but he did not seem to be looking for a mechanical lift. He stated he saw NA #8 go into Resident #85's room and come out. The Administrator stated he asked NA #8 to come to his office and while we were waiting for the police to arrive, NA #8 asked to use the men's room. While NA #8 was in the rest room, the officer arrived. The officer searched NA #8 and he found a couple of	F 602	3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: Education on Abuse Prevention, to include Misappropriation, was conducted with staff and agency by the Director of Nurses and Staff Development Coordinator and was completed on 8/11/ 2023. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training will not be allowed to work until the training is completed. On 11/22/2023 the Regional Nurse Consultant educated the Administrator on the continued monitoring of abuse allegations/incidents through the Quality Assurance Process to assure that allegations of abuse are being addressed following facility policy. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor this issue using the Abuse Reporting Quality Assurance Process for adherence to the abuse process. Audits for abuse/misappropriation will be conducted weekly x 4 weeks and monthly for 6 months or until resolved. Audits will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as	

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F 602	Continued From page 9 dollars on him, but that was all. The Administrator stated NA #8 denied taking Resident #85's wallet and was sent home. The Administrator stated the officer wanted to check the men's room NA #8 used and we found the toilet was overflowing. The Housekeeping Director was notified and started snaking (using a long thin drain cleaning tool) the toilet and little by little one of Resident #85's items would come out after another. The Administrator stated he notified the officer and sent pictures of what was retrieved from the toilet for evidence. The Administrator stated no wallet or cash was found but we retrieved everything else. The Administrator stated NA #8 was an agency nurse aide and had received orientation regarding the long term abuse policy and procedure when he began working at the facility. The Administrator stated the investigation was still in process with the Police Department and he did not know the outcome of the investigation at this time.	F 602	appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of compliance: 12/15/2023	
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 record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of 1) nutritional status (Resident #66), 2) skin conditions (Resident #88), and 3) urinary continence (Resident #86) for 3 of 26 residents whose MDS assessments were reviewed. Findings included:	F 641	F-641 Accuracy of Assessments 1. Corrective actions Resident #66 Minimum data set annual assessment with Assessment Reference date of 9/26/2023 reviewed and resident does not have therapeutic diet or 10% weight gain in the last 6 months coded on the MDS. Minimum data set assessment with Assessment reference date of	12/15/23

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1). Resident #66 was admitted to the facility on 10/8/21 with diagnosis which included in part: stroke with hemiparesis, dysphagia (swallowing difficulty), congestive heart failure, and diabetes.

Review of Resident #66's electronic health record revealed a 1/28/22 physician order for low concentrated sweets diet regular texture with thin consistency liquids.

Review of Resident #66's progress notes revealed a 8/16/23 registered dietician note, which indicated resident received a low concentrated sweets diet with double portions and had significant weight gain in the past 180 days.

Review of Resident #66's weight summary indicated:

9/22/2023 210.0
8/2/2023 205.2
7/13/2023 201.0
6/1/2023 194.8
5/18/2023 188.6
4/7/2023 189.2
3/29/2023 187.2
2/10/23 185.2

Review of Resident #66's 9/26/23 annual Minimum Data Set (MDS) indicated resident was cognitively intact, required supervision with eating. The Nutritional Status section of the MDS indicated Resident #66 had no swallowing or chewing difficulty, had a weight of 210 pounds and did not have a 10 percent weight gain in the last 180 days. Therapeutic diet was not coded in the nutritional approaches section of the MDS.

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9/26/2023 was modified and corrected by the facility MDS Nurse on 11/20/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment.
Resident #88 Minimum data set admission assessment with Assessment reference date of 12/5/2022 was reviewed and findings revealed resident did not have two stage IV pressure ulcers coded on the MDS. Minimum data set assessment with assessment reference date of 12/5/2022 was modified and corrected by the facility MDS Nurse on 11/20/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment.
Resident # 86 Minimum data set quarterly assessment with ARD of 11/13/2022 was reviewed and findings revealed resident had a catheter and urinary continence was incorrectly coded on the minimum data set assessment. Minimum data set assessment with Assessment reference date of 11/13/2022 was modified and corrected by the facility MDS nurse on 11/20/2023 to reflect accuracy at the time of the assessment reference date look back timeframe of the assessment.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents have the potential to be affected by the alleged deficient practice. A 100 % audit of the most recent completed Minimum data set assessment in the past 30 days of all current residents will be completed in order to identify if the

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Interview with the MDS Nurse on 11/2/23 at 12:51 PM revealed Resident #66 received a low concentrated sweets diet which was classified as a therapeutic diet per the Resident Assessment Instrument manual. The MDS Nurse reviewed Resident #66's weights and indicated the resident had a significant weight gain in the past 6 months and this should have been coded on the 9/26/23 annual MDS assessment. The MDS Nurse stated the weight change and diet were coded incorrectly. The MDS Nurse further stated that she had been in the position for about a year and was still learning and sometimes she completed the nutritional section of the MDS and sometimes the Dietary Manager completed it.

Interview with the Administrator on 11/2/23 at 4:50 PM revealed he expected the MDS assessments would be accurate, and that further education and monitoring was needed to ensure this.

2). Resident #88 was admitted to the facility on 12/2/22 with diagnoses which included: influenza, emphysema, congestive heart failure, and dementia.

Review of Resident #88's electronic medical record revealed the following physician orders dated 12/2/22:

- Vashe Wound Therapy Solution (antimicrobial wound cleanser) apply to Left iliac crest topically every day and night shift for pressure injury stage 4. Cleanse wound with Vashe solution, moisten plain packing strips with Vashe solution and insert moistened strips loosely into the wound tunnel. Cover with an abdominal pad and secure with

F 641

following questions were coded accurately on the Minimum data set assessment:
- H0300- Urinary incontinence
- K0310- weight gain
- K0520D- Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- M0300D- Stage IV Pressure ulcers

This audit will be completed by regional minimum data set consultant no later than 11/21/2023. Any resident who is identified as having inaccurate coding of any one or more of the above questions will have a correction of that assessment completed immediately by the facility Minimum Data Set Coordinator. Any necessary Minimum data set corrections will be completed no later than 11/21/2023

3.0Systemic Changes

By 11/20/2023, the Senior Nutrition Service Coordinator will complete an in-service with the Certified Dietary Manager Consultant that includes the importance of thoroughly reviewing each resident’s medical record in order to ensure that the assessment is coded accurately. Special emphasis will be placed on coding Section K and completing Dietary Review UDA per MDS schedule.

By 11/21/2023, the regional Minimum data set consultant will complete an in-service training with the facility Minimum Data Set Nurse that includes the importance of thoroughly reviewing each resident’s medical record in order ensure that the

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cloth tape.

- Apply Vashe Wound Therapy Solution (antimicrobial cleansing solution) to sacral topically every day
and evening shift for Pressure Injury Stage 4. Cleanse wound with Vashe moistened gauze, moisten rolled gauze with Vashe and insert into wound including undermined area at 6 o'clock margin. Cover with gauze,
abdominal pad, then secure with cloth tape.

Review of Resident #88's progress notes revealed a 12/5/22 Nursing Review note which indicated resident had wounds to the buttocks and ischial crest.

Resident #88's 12/5/22 admission MDS assessment indicated resident had severe cognitive impairment, required extensive assistance with bed mobility and transfers and had 1 unhealed Stage 4 pressure ulcer present on admission.

Review of a Weekly Pressure Ulcer Review assessment signed on 12/13/22 indicated Wound #1 was assessed as a Stage 4 pressure ulcer to the left iliac crest with an onset date of 12/2/22.

Review of a Weekly Pressure Ulcer Review assessment signed on 12/13/22 indicated Wound #2 was assessed as a Stage 4 pressure ulcer to the sacrum with an onset date of 12/2/22.

Interview on 11/1/23 at 11:05 AM with the Wound Care Nurse revealed Resident #88 had 2 Stage 4 pressure ulcers present on admission. The Wound Care Nurse indicated Resident #88 had a Stage 4 pressure ulcer to the left iliac crest and a

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assessment is coded accurately. Special emphasis will be placed on the following areas of the Minimum Data Set assessment:
-H0300 Urinary Continence
-K0310- weight gain
-K0520D- Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
-M0300D- Stage IV Pressure ulcers

The MDS needs to be thoroughly reviewed for accuracy prior to closing and locking the assessment.
This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

4. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
The Administrator or designee will begin auditing 5 random recently completed minimum data set assessments for accuracy in coding on the Minimum data set assessment for H0300: urinary continence, K0310: weight gain, K0520D: therapeutic diet, and M0300D: stage IV pressure ulcers. This audit will be done weekly x 4 weeks and then monthly x 2 months using the audit tool titled “Accurate Coding of MDS Audit Tool”.
Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by

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F 641	Continued From page 13 Stage 4 pressure ulcer to the sacrum on admission. Interview with MDS Nurse on 11/2/23 at 12:51 PM revealed she had been in the position for the past year. The MDS Nurse acknowledged that Resident #88 had 2 pressure ulcers noted on admission and the MDS should have been coded as 2 pressure ulcers instead of 1. The MDS Nurse did not know why the 12/5/22 admission MDS was coded as 1 pressure ulcer instead of 2, other than human error. Interview with the Administrator on 11/2/23 at 4:50 PM revealed he expected the MDS assessments would be accurate, and that further education and monitoring was needed to ensure this. 3) Resident #86 was admitted to the facility on 02/22/17 and discharged on 01/15/23. Review of a quarterly MDS assessment dated 11/13/22 documented Resident #86 had an indwelling urinary catheter and was occasionally incontinent of urine. In an interview with the MDS Nurse on 11/2/23 at 3:30 PM she stated urinary incontinence should have been coded "not rated" because the resident had a catheter. She noted this field in the assessment was auto populated from the aide charting and was incorrect. She explained she should have noticed it was incorrect and changed the answer to "not rated". She said she simply missed it, and it was a coding error. In an interview with the Administrator on 11/02/23 at 4:07 PM he stated he expected the information in the MDS assessments to be accurate.	F 641	the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and/or Director of Nursing. Date of Compliance: 12/15/23	

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F 689 SS=G	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 record review and staff and resident interviews the facility failed to notify the nurse when a resident refused to be transferred with a mechanical lift and two nurse aides decided to transfer the resident (Resident #2) by manually lifting the resident from the bed to the shower bed causing her to fracture her tibia for 1 of 4 residents reviewed for accidents. Findings included: Resident #2 was admitted to the facility on 12/15/2011. Diagnoses included cerebral palsy (spastic paralysis causing impaired muscle coordination), osteoporosis (brittle and fragile bones), anxiety, vitamin D deficiency, contractures to left elbow and left wrist, and fracture of shaft of right tibia. A review of Resident #2's care plan updated 11/03/22 revealed a plan of care for at risk for falls related to resistance to getting out of bed and refusal of care of the mechanical lift. Requires a mechanical lift for all transfers out of bed with a goal that resident would not sustain serious injury over the next 90 days with interventions to include, in part, use mechanical	F 689	Past noncompliance: no plan of correction required.	

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lift with two staff to get in and out of bed. A plan of care for receiving pain medication therapy related to cerebral palsy with joint restrictions and muscle spasms with interventions to include, in part, reposition in bed for comfort and encourage to get out of bed, and a plan of care for osteoporosis with risk for injuries and fractures and pain related to hypocalcemia and vitamin deficiency. Goal to remain free of injuries or complications related to osteoporosis with interventions to include observe for and document/report to the physician any signs or symptoms of complications related to osteoporosis, acute fractures, compression fractures, and pain.

The Minimum Data Set (MDS) annual assessment dated 11/11/22 revealed Resident #2 was cognitively intact. She demonstrated no behaviors and required extensive assistance with two staff physical assistance with bed mobility and transfers. Resident #2 was not coded as having any falls during this assessment.

A review of the physician's orders revealed Resident #2 was receiving the following medications:

" Tylenol 325 milligrams (mg) one tablet three times a day and 2 tablets every 4 hours as needed for pain/fever written on 04/22/22.
" Evista 60 mg give one tablet by mouth one time a day for osteoporosis written on 04/22/22.
" Norco (opioid pain medication) tablet 5-325 mg give one tablet three times daily for pain written on 04/23/21.
" Flexeril (muscle relaxing medication) 10 mg one tablet twice daily for muscle spasms written on 07/25/11.

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" Pain assessment every shift - ask patient if in pain according to pain scale and document response written on 04/23/21.

A review of the incident report dated 11/02/22 at 10:42 AM by Unit Manager revealed Resident #2 complained of pain in right leg, hip, and knee. Resident #2 was able to move right leg and toes and slightly bend her right knee. Resident #2 was offered Tylenol for pain but declined stating the medication she took routinely for pain was enough at this time. The Nurse Practitioner was in the building and made aware.

A Nurse Practitioner (NP) progress note written on 11/02/22 AM revealed Resident #2 was seen on 11/02/22 resting in bed. Resident #2 reported pain to her right knee that radiated to right hip with onset after shower on 10/30/22. She had continuous sharp pain rating 8 out of 10 and was worse with moving or touching knee. Resident #2's right knee had mild edema (swelling) and no redness. Resident #2 stated when she was lying still it reduced the pain but did not alleviate the pain. There was no pain on palpation of right hip and an x-ray was ordered for the right knee and hip.

A physician's order written on 11/02/22 revealed an x-ray to right knee and hip 2 views related to pain.

A review of the x-ray results of the right knee dated 11/02/22 revealed Resident #2 had an acute obliquely oriented (broken at an angle) incomplete fracture at the proximal (near) tibial (shinbone) metaphysis (neck of bone where tibia starts to narrow) medially (middle), a new finding when compared to prior examination dated

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01/18/19 and mild osteoarthritis predominantly involving the knee.

A record review revealed on 11/03/22, Resident #2 was transferred via mechanical lift to a wheelchair for an appointment to a walk in clinic at nearby orthopedic center where resident was seen and a right leg immobilizer placed and resident returned to facility with orders.

A review of a physician's order written on 11/03/22 from the orthopedic center revealed an order for a right knee immobilizer to be worn at all times for 6 to 8 weeks.

A review of the Medication Administration Record from 10/30/22 through 11/02/22 revealed Resident #2 received her scheduled Norco 5-325 mg as ordered (three times daily).

The Medication Administration Record from 10/30/22 through 11/02/22 revealed Resident #2's pain was assessed on 10/30/22 and 10/31/22, and 11/01/2 and was recorded as "0" for day, evening, and night shift pain assessments. Resident #2's pain was assessed on 11/02/22 and was recorded at "8" for the day shift.

Review of an investigation conducted by the facility revealed on 11/02/22 Unit Manager was made aware by Resident #2 that her right leg was hurting. The Unit Manager completed a physical assessment on Resident #2 and reported findings to the Nurse Practitioner. The Nurse Practitioner assessed Resident #2 and ordered an x-ray of her right leg. On 11/03/22, Resident #2 was transferred via a mechanical lift to a wheelchair for an appointment at a walk-in orthopedic clinic where resident was seen and right leg

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immobilizer was placed. Resident returned to the facility with orders. On 11/04/22, Resident #2 reported she had no new pain from 10/30/22 to 11/02/22. Resident had a diagnoses of osteopenia, cerebral palsy and refused to use the mechanical lift. The root cause of the fractured leg was noted that Nursing Assistants demonstrated lack of knowledge about who to report residents' refusal of using the mechanical lift and did not follow the Kardex (care guide specific to resident's needs) in Resident #2's care plan.

The MDS annual assessment dated 10/08/23 revealed Resident #2 was cognitively aware and required extensive assistance with two person physical assistance with bed mobility, total dependence with two staff physical assistance with transfers.

An interview was conducted with Resident #2 on 10/30/23 at 1:10 PM. Resident #2 revealed she did not get out of bed and that was her choice. Resident #2 stated she had a fall and fractured her right leg because she fell off a mechanical lift. Resident #2 stated she could not recall what had happened when she fell off the lift or when she fell off the lift. Resident #2 stated she no longer had that pain in her right leg.

An observation of Resident #2 on 10/30/23 at 1:10 PM revealed an alert and oriented resident lying in bed with head of the bed elevated. Resident #2 did not demonstrate any signs or symptoms of pain. Resident was watching TV and waiting for her lunch to arrive.

An interview was conducted via phone with Nurse Aide (NA) #2 on 11/02/23 at 12:37 PM. NA #2

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F 689	Continued From page 19 stated Resident #2 refused to use the mechanical lift so we transferred her with two person assistance. NA #2 stated that on 10/30/23 at around 7:00 PM she and NA #1 were putting Resident #2 in the shower bed using a two person technique with her at the head of the bed to move Resident #2's shoulders and NA #1 at the bottom of bed to move Resident #2's legs. NA #2 stated we had the shower bed beside Resident #2's bed and NA #1 placed bath blankets on the shower bed, a pillow for her head, a pillow for under her legs and a pillow for under her feet for cushioning. NA #2 reported NA #1 was holding Resident #2 from her legs and she was at the top holding the resident's arms and we shifted Resident #2 over to the shower bed. NA #2 stated Resident #2 had no complaints of new pain during the transfer, during her shower, or during the transfer from the shower bed back to her bed. NA #2 stated Resident #2 was always complaining of aches and pains, but she did not say she had new pain. NA #2 stated we have used the mechanical lift with her, but that particular time she refused. NA #2 stated she believed NA #1 (who was assigned to Resident #2) let the nurse know, but she could not remember because it was over a year ago. NA #2 stated Resident #2 complained of pain to her knees and legs all the time and that was why we kept pillows under her legs while in her bed and in the shower bed. A follow up interview was conducted with Resident #2 on 11/02/23 at 10:00 AM. Resident #2 revealed she recalled that NA #1 and NA #2 were getting her ready for her shower and they transferred her from the bed to the shower bed. Resident #2 confirmed she did not fall off the mechanical lift but that she refused to use the	F 689		

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mechanical lift so the nurse aides transferred her with one of the aides holding her shoulders and one of the aides holding her legs and slid her on to the shower bed. She stated at the time she did not have any new pain to her right leg. She stated she took her shower and they transferred her back to bed the same way and she did not have any new pain to her right leg. Resident #2 stated she could not remember when her knee started to hurt or when she reported the new pain to the nurse. Resident #2 added, she did not like to be transferred on the mechanical lift but knew that it was for her safety.

A phone interview was conducted with Nurse #2 on 11/02/23 at 12:48 PM. Nurse #2 stated she had no recollection of any nurse aides reporting to her that Resident #2 was refusing to use the mechanical lift to be transferred. Nurse #2 stated she did not recall being informed that Resident #2 had any complaints of new pain on 10/30/23. Nurse #2 added, Resident #2 had chronic pain and received routine pain medications. Nurse #2 added, if she had been told by the NA that Resident #2 was refusing to be transferred with the mechanical lift, she would have explained to Resident #2 that it was for her safety to use the mechanical lift whenever she was being transferred.

A phone interview was conducted with Medication Aide (MA) #3 on 11/02/23 at 2:18 PM. MA #3 confirmed he was assigned to Resident #2 from 7:00 PM to 7:00 AM on 10/30/22 and 10/31/22. MA #3 stated he could not recall if any nurse aides reported to him that Resident #2 refused to be transferred with a mechanical lift on 10/30/22. He also stated Resident #2 had chronic pain but he was not made aware of any new pain from

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F 689	Continued From page 21 Resident #2. An interview was conducted with MA #2 on 11/02/23 at 9:50 AM. MA #2 reported she was assigned to Resident #2 on 10/31/23 from 7:00 AM to 7:00 PM. She stated she was not made aware of any new pain Resident #2 had nor was she made aware that Resident #2 had her shower on Sunday 10/30/23. She stated she usually had a shower on Mondays and Thursdays. MA #2 stated Resident #2 had chronic pain and she received scheduled pain medicine which she administered on 10/31/23, but Resident #2 never indicated she had new knee pain. An interview was conducted with the Unit Manager (UM) on 11/01/23 at 3:10 PM. The UM reported on 11/02/22 she was called to Resident #2's room because she was complaining of pain. She stated she offered Resident #2 Tylenol, but she refused and added she asked Resident #2 where she was hurting and she stated her right knee. The UM stated she told the Nurse Practitioner (NP) #1 and she ordered an x-ray. The UM stated when she assessed Resident #2 she was able to move her right leg and toes and slightly bend her right knee. The UM stated Resident #2 told her that she got hurt when she was transferred from her bed to the shower bed by NA #1 and NA #2 on Sunday 10/30/22. The UM reported Resident #2 refused to use the mechanical lift and the nurse aides decided to transfer her without using the mechanical lift. Attempted a phone interview with NA #1 on 11/01/23 at 7:30 PM, on 11/02/23 at 10:30 AM, and a text message at on 11/02/23 at 11:58 AM. NA #1 no longer worked at the facility and did not	F 689		

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return any calls.

Attempted a phone interview with the Nurse Practitioner (NP) #1 via phone on 11/02/23 at 2:20 PM. NP #1 no longer worked at facility and did not return call.

Attempted a phone interview with the Director of Nursing (DON) on 11/02/23 at 3:10 PM. The DON no longer worked at the facility and did not return call.

An interview was conducted with the Administrator on 11/02/23 at 3:15 PM. He reported it was determined that the nurse aides should have followed Resident #2's Kardex and transferred her with the mechanical lift for her safety. The Administrator added, the nurse aides should have informed the nurse that she refused to be transferred with the mechanical lift and they should not have transferred her without the lift. The Administrator stated once she complained of new pain, an x-ray was done and determined that she had a fracture to her tibia and she was sent to the orthopedic clinic for a brace. He stated he initiated a plan of correction as a result of her injury and the nurse aides not following the Kardex.

Failure to provide supervision to prevent accidents:

The facility initiated the following plan of correction.

1. On 11/02/22, the Unit Manager (UM) completed a head to toe assessment on Resident #2. The results included increase pain and edema to right knee. The UM reported the

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F 689	Continued From page 23 finding to NP #1 who then assessed Resident #2 and ordered an x-ray of the right leg. The x-ray was completed and resulted in fracture to right tibia on 11/03/22. Resident #2 was taken to the outpatient orthopedic clinic on 11/03/22 and was assessed by a provider who ordered a leg brace for 6-8 weeks. There were no changes to medications due to resident having scheduled Norco that was currently effective. Skin checks were ordered every shift to assess for any skin breakdown under the brace. 2. On 11/03/22, the Director of Nursing (DON) identified residents that were potentially impacted by this practice by completing a review of all interviewable residents for the last 14 days for any similar incidents of residents declining interventions for their transfer status. This was completed on 11/03/22. The results included: no other incidents identified. On 11/03/22, the DON and MDS Nurse audited all resident care plans to assure the transfer status was up to date. All care plans were up to date. On 11/03/22, the DON and Staff Development Coordinator (SDC) Nurse audited all NAs and nurses, including agency NAs and nurses, to assure they could access the Kardex and knew how to find the transfer status of the resident. The results included: All NAs and nurses, including agency NAs and nurses, were competent with using the Kardex. On 11/03/22, the DON interviewed NAs and nurses for incidents of refusal to follow the designated transfer status indicated on the Kardex/care plan. The results included: Resident #2 was the only resident refusing to use the mechanical lift and the resident's Kardex/care plan was updated to reflect resident's refusal of the mechanical lift.	F 689		

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F 689	Continued From page 24 3. On 11/03/22, the DON began in services on all NAs and nurses, including agency NAs and nurses, on following the resident care plan/intervention process. This training will include all current above staff including agency. This training included: accessing the Kardex prior to initiating care of transferring a resident, resident refusal to follow the identified transfer status and notification of the nurse before transferring the resident and how to access the Kardex. 4. As of 11/08/22, 100% staff members have attended the in-service. The DON will ensure that any of the above identified staff who did not complete the in service training by 11/08/22 will not be allowed to work until training was completed. The DON/designee will observe 5 resident transfers on various shifts/days of the week to include weekends, weekly for 2 weeks and monthly for 3 months or until resolved for compliance with following the Kardex/care plan. Reports will be presented to the weekly Quality Assurance (QA) Committee by the Administrator or DON to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA meeting. The weekly QA meeting was attended by the Administrator, DON , MDS Coordinator, Therapy, and the Dietary manager. Validation of the corrective action was completed on 11/02/23. This included staff interviews regarding transferring residents according to their Kardex/care plan and to report to nurse if a resident refused to be transferred according to their Kardex/care plan to ensure understanding	F 689		

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F 689	Continued From page 25 and knowledge of the training provided. An interview with Resident #2 revealed she understood the use of the mechanical lift for her transfers was for her safety, and Resident #2's care plan was updated to reflect refusal of mechanical lift for transfers. The audits were verified and there were no concerns identified. The facility's alleged compliance with the corrective action plan on 11/08/22 was validated.	F 689		
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.	F 761		12/15/23

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F 761	Continued From page 26	F 761		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility failed to discard expired bottles of medication that were stored in the Rehab medication cart for 1 of 3 medication carts inspected.

Findings included:

The Rehab medication cart was inspected on 11/02/23 at 9:25 AM with the Director of Nursing present and was found to have the following expired medications on the cart:

1. Rena-Vite supplement that had expired 10/23.
2. Sodium Chloride 1 gram that had expired 9/23.
3. Aspirin 325mg that had expired 10/23.
4. Travel Ease Meclizine 25mg that had expired 9/23.
5. Gas Relief 180 mg (Smethicone) that had expired 9/23.
6. Zinc 50 mg that had expired 10/23.

In an interview with the Director of Nursing on 11/02/23 at 9:30 AM she stated the cart had been inspected on 10/30/23 by a Medication Tech and nurse. She had expected any expired medications to be removed from the cart and destroyed.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F761
The facility failed to discard expired bottles of medication on 1 of 3 carts.

1. Corrective action for resident(s) affected by the alleged deficient practice:
The expired medications were removed from the cart on 11/2/2023 by the SDC and appropriately disposed of. No resident was identified to be affected.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
Audits of all medication carts and the medication storage rooms were completed on
11/2/2023 by the Director of Nurses. No other undated or expired medications were found.

3. Systemic changes.
All nurses, medication aides and agency nurses/med aides will be re-educated by

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F 761	Continued From page 27	F 761	the Director of Nurses/Staff Development Coordinator on the facility medication storage, dating policy and disposition of medications for residents. This will be completed by 12/14/2023. The pharmacist consultant was notified of the survey findings on 11/20 /2023 by the Director of Nurses and will perform monthly audits of the medication carts and medication room to assist the facility in discarding, monitoring, dating of medications to assure that all expired medications are removed from the medication carts timely. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will audit medication carts on all halls weekly for 2 weeks and then monthly for 3 months or until resolved for compliance with the disposition of expired medications. The Pharmacist Consultant will submit a monthly report to the Director of Nursing. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard. The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, Minimum Data Set Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director,	

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F 761	Continued From page 28	F 761	Medical Director and the Director of Social Services. Date of Compliance: 12/15/2023	
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 observation, record review, resident and staff interviews, the facility failed to ensure food was palatable for 6 of 6 residents (Resident #66, Resident #9, Resident #15, Resident # 45, Resident #55, Resident #30) reviewed for food palatability. Findings included: a). Resident #66 was admitted to the facility on 10/8/21. Review of Resident #66's 9/26/23 annual Minimum Data Set (MDS) indicated resident was cognitively intact. Interview on 10/30/23 at 11:53 AM with Resident #66 revealed the food was usually cold, he often could not tell what the meals were, and the food usually did not taste good	F 804	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F804 1. For dietary services, a corrective action was obtained on 10/30/2023 and 10/31/2023. Based on observation, record review, and resident and staff interviews it was noted	12/15/23

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F 804	Continued From page 29 A follow up interview with Resident #66 on 10/31/23 at 5:45 PM, Resident #66 stated it was frustrating when the food was not palatable. b). Resident #9 was admitted to the facility on 11/15/21. Review of Resident #9 ' s 9/18/23 quarterly MDS assessment indicated resident was cognitively intact. Interview with Resident #9 on 10/30/23 at 12:21 PM revealed the food was not prepared good and the meals did not look or taste good. Observation of the lunch meal on 10/30/23 at 2:10 PM revealed Resident #9 was served a patty melt sandwich on bread and a small dish of brussels sprouts in liquid. Resident #9 tasted the sandwich and stated she could not eat it as it did not taste good. Resident # 9 requested the meal tray be removed and proceeded to eat snacks that her family provided. A follow up interview with Resident #9 on 10/31/23 at 5:15 PM revealed she kept snacks in her room and her family brought her meals because the food did not look or taste good. Resident #9 indicated dinner usually did not look or taste good. Resident stated she would really like a good meal. c). Resident #15 was admitted to the facility on 4/26/22. Review of Resident #15 ' s 9/22/23 quarterly MDS assessment indicated resident was cognitively intact.	F 804	the facility failed to provide palatable food to 6 of 6 residents. Resident #66 noted during interview 10/30/2023 and 10/31/2023 food was cold, without taste, and unidentifiable. On 10/30/2023 Resident #9 observed trying a sandwich and reported unable to eating it due to not tasting good; reported dinner usually not looking or tasting good. Resident #15 noted food often without taste and served cold. On 10/30/2023 Resident #15, #30, and #55 stated dinner inedible. Resident #45 noted during interview on 10/30/2023 food at the facility was terrible and relied on outside food. Dietary Manager met with residents #66, #9, #15, #55, #45, and #30 to review dietary concerns and complaints. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 11/17/2023 the Senior Nutrition Service Coordinator completed a test tray and discussed findings with Administrator and Dietary Service Director. Food Committee organized with assistance of Activities Director to have separate group time for residents to converse dietary concerns, preferences, and complaints. First meeting for the Food Committee scheduled for 11/29/2023 and a second meeting scheduled for 12/14/2023. Meal Delivery Schedule Log initiated to address meal pass times and concerns for cold food. Food preferences and meal tickets will be	

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F 804	Continued From page 30 Interview with Resident #15 on 10/30/23 at 11:31 AM revealed the food did not taste good or look appetizing. Resident #15 indicated the food was often served cold. A follow up interview with Resident #15 on 10/31/23 at 5:40 PM revealed dinner was served whenever they decided to send it. Resident #15 stated the supper meal on 10/30/23 was a large, greasy turkey wing that was not edible, so she just went to bed without much to eat that night. d). Resident #45 was admitted to the facility on 06/11/21. Review of a quarterly MDS assessment dated 09/13/23 indicated Resident #45 had intact cognition. In an interview with Resident #45 on 10/30/23 at 12:07 PM she stated the food at the facility was terrible. She commented that she could not eat it. An observation of her room during the interview revealed copious amounts of snacks stored in plastic bins beside her bed and ¼ of her bed covered with more bags of store bought snacks that had been brought in for her. e). Resident #55 was admitted to the facility on 08/22/19. Review of a quarterly MDS assessment for Resident #55 indicated he was cognitively intact. In an interview with Resident #55 on 10/31/23 at 12:05 PM he stated he had the turkey wings the evening before that he thought were fully cooked,	F 804	reviewed and updated for all residents. All residents with a BIMs of 12 or higher will receive Meal Selection Program overview and be added as desired. 3.Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: •Meal objectives and procedures •Focus on dining experience Test Trays will be completed to ensure satisfactory dining experience. Dietary Manager, Administrator, and/or Dietitian will attend Food Committee as invited and follow up with any food complaints as identified. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will complete a test tray weekly x 4 weeks and then monthly x 2 month. Monitoring will include reviewing food items for appearance and taste as well as visiting with residents and attending resident	

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F 804	Continued From page 31 but they were cold in the middle and didn't taste very good to him. f). Resident #30 was admitted to the facility on 04/19/23. Review of a quarterly assessment dated 08/21/23 for Resident #30 indicated she had intact cognition. In an interview with Resident #30 on 11/2/23 at 9:05 AM she stated most of the time the food she was served was not warm. She noted the turkey wing she had been served was skin and bone with no meat and she could not eat it. A picture she had taken of the meal was viewed. She stated she had recently been served corn chowder and the carrots in the soup were served whole-they were not sliced or chopped. She also reported she was recently served mashed potatoes that were so cold they had crusted and had to be chipped off and fell off in blocks. She could not eat them. Interview with the Dietary Manager on 11/1/23 at 2:50 PM revealed she had been in the position since April of this year. The Dietary Manager stated she was aware of the issue with the food and the concerns expressed. The Dietary Manager stated she had not done any analysis of the problem regarding the food and there was no auditing in place for monitoring. Interview with the Administrator on 11/2/23 at 4:50 PM revealed he was aware of the residents ' concerns regarding the food but there had not been any follow-up with the dietary issues. The Administrator stated he had tried to let the staff grow in their role and develop leadership and	F 804	meetings when to address concerns and complaints in a timely manner. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 12/15/2023	

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F 804	Continued From page 32 accountability. The Administrator revealed there were more concerns regarding food lately and he should have implemented measures to address the concerns.	F 804		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff, resident and physician interviews, the facility failed to provide evening snacks to diabetics and non-diabetics and failed to provide residents with lunch and dinner meals according to the meal schedule comparable to normal mealtimes in the community for 4 of 4 halls observed for dining causing residents (Resident #55, #1, #34, #12, # 46, #30 #45, #332, #6, #33, #9, and #66) to	F 809	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	12/15/23

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F 809

Continued From page 33
complain of feeling hungry.

Findings included:

A meal schedule was provided on 10/30/23 with meal delivery times recorded as scheduled in 10 minute intervals for the 4 different halls (100 Hall, 200 Hall, 300 Hall and 400 Hall).

Breakfast schedule serving times were ranged from 7:30 AM - 8:10 AM
Lunch schedule serving times were ranged from 12:00 PM - 12:50 PM
Dinner schedule serving time were ranged from 5:30 PM - 6:10 PM

1.
a.) Resident #55 was admitted to the facility on 08/22/19. Review of a quarterly Minimum Data Set (MDS) assessment dated 10/02/23 for Resident #55 documented he had intact cognition.

In an interview with Resident #55 on 10/31/23 at 12:05 PM, he stated the night before (10/30/23) dinner did not come until 7:45 PM and he was very hungry. He stated he does not receive a snack at bedtime and he was not offered one.

b.) Resident #1 was most recently admitted to the facility on 05/02/23. Review of a quarterly MDS assessment dated 08/02/23 for Resident #1 documented she had intact cognition.

In an interview with Resident #1 on 11/02/23 at 8:47 AM, she stated the evening meal was usually late and she got hungry. Resident #1 reported she was a diabetic and did not get a snack at bedtime and was not offered one.

F 809

constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F809
1. For dietary services, a corrective action was obtained 10/30/2023-11/2/2023

Based on observation, interviews, and records reviewed it was noted dietary services failed to maintain frequency of meals. Meal services noted to be variable, at times exceeding 14 hours between a substantial evening meal and breakfast, and snacks not provided.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice. On 11/8/2023 the Dietary Service Director and Administrator met to review the current meal schedule and dietary staff schedules; no changes made. On 11/9/2023 Dietary Service Director initiated a Meal Delivery Schedule Log which includes opportunity to interview residents during meal times.

Resident dining in Dining Room reviewed 11/8/2023; noted Dining Room unable to provide meal for all diners in a timely manner. Secondary Dining Room opened 11/13/2023 to ensure all residents dining outside of their room accommodated.

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Resident #1 stated she felt she needed a snack at bedtime because of her diabetes.

c.) Resident #34 was most recently admitted to the facility on 11/02/22. Review of a quarterly MDS assessment dated 09/12/23 documented Resident #34 had intact cognition.

In an interview with Resident #34 on 11/02/23 at 8:52 AM, she stated lunch and supper were usually late and she got hungry waiting for the meals to arrive. Resident #34 reported she was a diabetic and was not offered or provided a snack at bedtime.

d.) Resident #12 was most recently admitted to the facility on 05/02/23. Review of an annual MDS assessment dated 09/27/23 for Resident #12 documented she had intact cognition.

In an interview with Resident #12 on 11/02/23 at 8:55 AM, she stated she got a snack at bedtime if she asked for one but staff did not always come around so she could ask and therefore she doesn't receive a snack. Resident #12 stated she does get hungry waiting for supper because it comes so late in the evening.

e.) Resident #46 was most recently admitted to the facility on 04/04/23. Review of a quarterly MDS assessment dated 10/05/23 for Resident #46 documented he had intact cognition.

In an interview with Resident #46 on 11/02/23 at 9:01 AM, he stated his meals come very late in the evening and his stomach "grumbles" with hunger. He reported he only got a snack at bedtime if he asked for one.

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On 11/17/2023 Senior Nutrition Service Coordinator completed audit of all diabetic snack orders and updated meal ticket report system.

Meal schedule and efforts to maintain meal schedule discussed during Food Committee 11/29/2023.

3. Systemic changes

In-service education was provided to all full time, part time, and as needed staff. Topics included:
•Scheduled meal time policies and procedures.
•Current meal schedule.
•Shift start times and break times.
Dietary staff clock-in tardiness for shift and breaks will be addressed in a timely manner.
List of diners attending dining areas updated and provide to dietary daily.
Dietary staff to replenish Nourishment Rooms with snacks on AM and PM shifts.
During PM staff dietary to provide list of residents to receive diabetic snacks; documentation of consumption of diabetic snack maintained in MAR.
Meal times to be reviewed and discussed as needed during Food Committee.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained.

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F 809	Continued From page 35 f.) Resident #30 was most recently admitted to the facility on 04/19/23. Review of a quarterly MDS assessment dated 06/26/23 for Resident #30 documented she had intact cognition. In an interview with Resident #30 on 11/02/23 at 9:10 AM, she reported most of the time the food was served late. Resident #30 commented that she got hungry between meals and she did not receive a snack at bedtime and she was not offered one. g.) Resident #45 was admitted to the facility on 06/11/21. Review of quarterly MDS assessment dated 09/18/23 for Resident #45 documented she had intact cognition. In an interview with Resident #45 on 11/02/23 at 11:00 AM with Resident #45, she stated the food was served late and she did not receive a snack at bedtime. In an interview with the Dietary Manager on 10/31/23 at 2:25 PM, she stated she had been working at the facility since the middle of April 2023. She stated the kitchen started plating food at 8:00 AM, 12:00 PM and 5:00 PM. She reported she did not keep a log of when meal trays left the kitchen. She commented that she had discussed with the residents about mealtimes and let them know she was working on getting the meal trays out on time. She stated the kitchen did not pass out snacks and that snacks were kept in the nourishment station and the nurse aides were supposed to let the kitchen know if the snacks needed to be replenished. The Dietary Manager added, the kitchen staff did not monitor the nourishment rooms and the kitchen staff did not prepare or provide	F 809	4. Quality Assurance monitoring procedure. The Dietary Service Director or designee will complete Meal Delivery Schedule Log daily x 3 months and then as needed. Procedures will be monitored weekly x 4 weeks then monthly x 2 months using the Meal and Snack QA Tool and with interviews completed on Meal Delivery Schedule Log. Monitoring will include auditing meal times and identifying root causes when meals served outside of scheduled meal times as well as ensuring snacks provided to nourishment rooms. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 12/15/2023	

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individually labeled bedtime snacks for diabetics.
2.

a) Resident #332 was admitted to the facility on 10/28/23. MDS assessment revealed Resident #332 was moderately impaired.

An interview was conducted on 11/01/23 at 8:20 AM with Dietary Cook #3. When asked about evening snacks, who offered or prepared them, and which halls received them, the cook said he was not sure about snacks and who provided them. He said as far as he knew the kitchen staff did not provide evening snacks to the nurses for residents who were diabetics.

An interview was conducted on 11/01/23 at 11:40 AM with Nurse #3. Nurse #3 stated the meals were always delivered late, with an example of 10/30/23 dinner trays arriving on the 300 and 400 halls close to 8:00 PM. The nurse said up to that point she had been passing out crackers to hungry residents right and left. She said the 300 and 400 halls did not offer or provide diabetic residents with specific labeled evening snacks.

An interview was conducted on 11/01/23 at 11:45 AM with Medication Technician (MT) #1. She said they did not offer or provide snacks like a sandwich. She said she usually passed out crackers when meals were late, which was usually all the time.

An interview was conducted on 11/01/23 at 11:50 AM with Physician #2. The Physician said the standard of care was that meals be delivered on time, which was important for diabetic residents. He also said it was important for evening snacks to be offered and provided to diabetics.

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An interview was conducted on 11/02/23 at 12:15 PM with Resident #332's family member. The family member stated on 11/01/23 she was with Resident #332 all day and evening. She said at no time during that time did staff offer Resident #332 any snacks. The family member stated the resident had a history of diabetes and should have been offered or given an evening snack. She indicated that she had asked staff several times for a bedtime snack to be given to the resident, and still no snacks had been offered or given to the resident.

An interview was conducted on 11/01/23 at 2:25 PM with the Dietary Manager (DM). The DM said she did not have a list of bedtime (HS) snacks available for all residents that were to receive a diabetic specific snack. The DM said they were not preparing or labeling any HS snacks for diabetic residents or non-diabetic residents.

An interview on 11/01/23 at 8:25 AM with the Administrator who stated his expectation was that all residents be offered HS snacks, and that the diabetic snacks should be labeled resident specific per their need.

3.

During the initial tour on 10/30/23 at 11:30 AM, Resident #6 and Resident #33 reported that lunch and dinner were always late. Resident #6 and #33 stated lunch would arrive more often than not around 2:00 PM and dinner would arrive around 7:30 - 8:00 PM. Resident #33 stated it was a long time between meals and by the time the meals arrived she was hungry.

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An interview was conducted with Nurse Aide (NA) #9 who was assigned to the 200 hall on 10/30/23 at 12:50 PM. NA #9 was asked when the meal trays were typically delivered to the hall. He stated that the lunch meal trays were sometimes on time and arrived around 12:30 to 12:45 and sometimes were later and added, "I guess it depends on the what they are cooking." NA #9 stated sometimes the residents would complain when lunch was served late.

An interview was conducted with Nurse #8 on 10/30/23 at 12: 17 PM. Nurse #8 reported she worked from 7:00 AM to 7:00 PM. She stated the meal trays were getting passed out to the residents later and later every day. She stated the breakfast meal was not served until 9:00 AM this morning and it should be on the 200 hall between 7:45 and 8:15 AM. She stated the lunch meal was not served until 2:00 PM on 10/29/23 and the residents did not receive their dinner tray until after 7:00 PM on 10/29/23. Nurse #8 stated she believed it has been brought to the management's attention by the residents via formal written complaints. Nurse #8 stated residents have complained to her about the meal trays being so late and she had reported the issue to the Director of Nursing (DON) who no longer worked at the facility.

An observation of the lunch meal was conducted on 10/30/23 starting at 12:45 PM on the 200 hall. The lunch tray meal cart arrived on the 200 hall (rooms 201 - 212) at 1:28 PM and the second meal cart arrived on the 200 hall (rooms 214 - 220) at 2:00 PM. This hall was the last scheduled hall to receive lunch meal trays.

a.) Resident #6 was admitted to the facility on

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05/01/20. The MDS quarterly assessment dated 10/18/23 revealed Resident #6 was cognitively intact.

An interview was conducted with Resident #6 on 10/30/23 at 2:10 PM. While interviewing Resident #6 her lunch meal tray arrived in her room. Resident #6 stated she was hungry and was happy lunch had finally arrived. Resident #6 added, "I don't eat a lot but I'm hungry!"

A follow up interview was conducted with Resident #6 on 10/31/23 at 9:40 AM. Resident #6 reported she did not get her dinner tray until close to 8:00 PM on 10/30/23. She stated she ate what she could but it was an enormous turkey wing and it was not very good.

b.) Resident #33 was admitted to the facility on 01/17/23. The MDS quarterly assessment dated 10/17/23 revealed Resident #33 was cognitively intact.

An interview was conducted with Resident #33 on 10/30/23 at 2:35 PM. Resident #33 was eating her lunch upon arrival to her room. Resident #33 stated "I was starving and it was about time the lunch tray arrived." She stated she received her lunch tray at 2:15 PM.

Upon arrival to the kitchen for a dinner observation, an interview was conducted with the Dietary Manager (DM) at 5:05 PM. The meal schedule was reviewed with the DM at this time and she reported the first cart should be out to the dining room by 5:15 PM and the second meal cart should be on the 100 hall by 5:30 PM. The DM affirmed the 100 hall tray cart would be on the floor by 5:30 PM.

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An observation of the kitchen staff while preparing the dinner meal was conducted starting at 5:05 PM on 10/31/23. Upon arrival to the kitchen, there was noted to be 4 staff in the kitchen to include the Dietary Manager (DM), the cook, and two dietary aides (DA). The steam table was not prepared with any food at this time and the cook was noted to be mixing the cooked entrée which was beef stroganoff with sour cream and placing it back in the oven at 5:10 PM. The DAs were noted to be preparing the beverages at 5:20 PM and the DM had just started preparing the baked bananas for dessert at 5:20 PM. At 5:25 PM, the cook began to prep the steam table with the entrée and mixed vegetables and checked the food temperatures. All the food was prepared and on the steam table with temperatures checked by 5:45 PM. The tray line had begun to start and the first cart was sent to the dining room at 6:00 PM.

A follow up interview with the Dietary Manager on 10/31/23 at 6:00 PM revealed she did not know why they were so late serving the meal trays this evening. She stated the cook started at 1:00 PM and some meals were harder to prepare than others. When asked if this was a difficult meal to prepare she stated, "No it was not." When asked why she supposed she got behind with getting the meal trays out on time, she replied, "I will have to get back to you on that."

A follow up interview was conducted with Resident #33 on 11/01/23 at 10:18 AM. Resident #33 reported she did not get her dinner meal tray until close to 7:00 PM on 10/31/23. She added, "I was hungry and this is ridiculous, having to wait so long for our dinner."

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A follow up interview was conducted with the DM along with the cook on 11/01/23 at 11:00 AM when asked why they thought the cook was not ready on time to get the dinner trays out to the 100 hall by 5:30 PM, the DM stated the staff was trying to meet the times on the schedule and we were doing the best we could. The DM stated she did not need more staff but she could not definitively say why the lunch and dinner trays were being served late. The cook stated she was doing the best she could.

An interview was conducted with the Administrator on 11/01/23 at 12:37 PM. The Administrator stated the time frame schedule for meals that was provided was in place for the previous Dietary Manager and there was no reason why the current Dietary Manager could not follow the same meal schedule. The Administrator stated he has had a performance improvement plan (PIP) in place with the Dietary Manager due to her poor time management for the last two weeks and will continue for another two weeks. He stated he has seen no improvement since the PIP was put in place. The Administrator stated he agreed that 2:00 PM for lunch being served and 8:00 PM for dinner was pushing it and was a little late. The Administrator added he was made aware that the meals were being served late by various residents as he walked the halls. He stated there were no formal grievances filed regarding meals being late, but there were some concerns from the Resident Council Meeting and that was when he put a PIP in place for the DM to include improvement with timeliness of meals, leadership, holding staff accountable, addressing issues timely, and engaging the dietary staff to help instead of the

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DM doing it all herself.
4.

a.) Resident #9 was admitted to the facility on 11/15/21. Review of Resident #9's 09/18/23 quarterly MDS assessment revealed Resident #9 was cognitively intact.

An observation on 10/30/23 at 2:00 PM revealed the meal trays arrived on the hall for the top of the 200 Hall, the last scheduled hall to receive lunch meal trays.

An interview with Resident #9 on 10/31/23 at 5:15 PM revealed Resident #9 ate her meals in her room on the 200 Hall. Resident #9 stated meals were frequently served late and were served whenever the kitchen decided to send them. Resident #9 stated there was supposed to be a schedule for meals, but they did not follow it. Resident #9 stated breakfast was frequently served as late as 9:30 AM, lunch frequently served as late as 2:00 PM and dinner frequently served as late as 8:00 PM. Resident #9 also stated no snacks were offered during the day or at night and she was often hungry between meals.

b.) Resident #66 was admitted to the facility on 10/08/21. Review of Resident #66's 10/08/23 annual MDS assessment revealed Resident #66 was cognitively intact.

An interview with Resident #66 on 10/31/23 at 5:45 PM revealed he ate meals in his room on the 200 Hall. Resident #66 stated meals were frequently late, and he was so hungry by the time dinner was served. Resident #66 stated it was frustrating.

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An interview with the Dietary Manager on 11/01/23 at 2:50 PM revealed she had been in the position since April of this year. The Dietary Manager stated she was aware of the issue with meals served late and the concerns expressed by the resident council. The Dietary Manager indicated the lunch meal was served late on 10/30/23 due to the cook did not properly preparing the sandwiches that were to be served and she had to start the meal over. The Dietary Manager further stated there was a snowball effect since the lunch meal was late then the dinner was also late. The Dietary Manager reviewed the meal schedule that was provided to the survey team and stated she had not seen this schedule before. She later stated she might have seen a copy of the meal schedule posted in the kitchen, but she was not sure of this. The Dietary Manager stated she had not done any analysis of the problem regarding the meals being served late and there was no auditing in place for monitoring meal service times.

An interview on 11/01/23 at 12:42 PM with the Administrator revealed he was aware of a problem in the facility with meals frequently served late and this was reported by the residents and the staff. The Administrator stated he reviewed the meal schedule with the Dietary Manager and discussed adhering to the schedule. The Administrator further stated there was no auditing or monitoring in place to track the adherence to the meal schedule.

F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		12/15/23

§483.60(i) Food safety requirements.

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The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews the facility failed to clean 1 of 3 ice machines used to provide ice for residents (300-400 hall ice machine).

The findings include:

An observation of an ice machine on 11/02/23 at 11:30 AM located in the nutrition room on the 300-400 hall revealed a black tinged substance located on the silver galvanized linear plate located inside the machine over the ice. This black substance was observed by the Maintenance Director.

An interview was conducted on 11/02/23 at 11:35 AM with the Maintenance Director. The Maintenance Director stated the ice machine was last serviced and cleaned by their vendor on

F 812

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F812
1. For dietary services, a corrective action was obtained on 11/02/2023.
Based on nourishment room observations on 11/02/2023, it was noted dietary

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07/18/23. He said nursing staff were supposed to clean out and wipe down the ice machine monthly and sign off on a log that the ice machine was wiped-out and cleaned, which they did not do. The Maintenance Director stated the ice machine needed to be consistently cleaned and sanitized to prevent mold or water borne pathogens from developing. The Maintenance Director stated the blackened substance he observed should not have been present inside the 300-400 hall ice machine with the ice, which could adversely affect the health of residents on the 300 and 400 halls.

An interview was conducted on 11/02/23 at 11:40 AM with the Administrator. The Administrator indicated there was no current cleaning schedule log for the 300-400 halls ice machine. He stated the Maintenance Director contacted their outside vendor to perform cleaning and maintenance on the ice machine that day, and that the ice machine was currently shut down until it could be cleaned and sanitized by the vendor.

F 812

services had failed to maintain cleanliness/sanitation for 1 of 3 ice-machines. On 11/02/2023 the ice machine was deep cleaned.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents have the potential to be affected by the alleged deficient practice. On 11/17/2023 the Nutrition Services Coordinator completed a walk-through of the nourishment rooms to ensure nourishments rooms met standards to store, prepare, and serve sanitary food. On 11/20/2023 refrigerators and ice-machines cleaned thoroughly.

3. Systemic changes
In-service education was provided to all full time, part time, and as needed dietary, and environmental staff on 11/22/2023.
Topics included:
•Inspections on shifts to observe all equipment in clean and appropriate to store, prepare, and serve food.
•Maintaining Cleaning Logs

Cleaning logs posted to ensure cleaning schedule recorded and kept up to date.

Maintenance to maintain equipment by keeping up to day on audits and maintenance request through TELS program.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for

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F 812	Continued From page 46	F 812	all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure. The Dietary Manager or assignee will monitor procedures for proper food storage and sanitation weekly x 4 weeks then monthly x 2 months using the Nourishment Room Inspection Tool which will observe that all food is labeled, dated, within proper dates, and stored in clean and working equipment. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Date of Compliance: 12/15/2023	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with	F 849		12/15/23

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F 849	Continued From page 47 a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility	F 849		

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for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property

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by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the

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F 849	Continued From page 50 hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interviews, Hospice staff interviews and record review the facility failed to maintain communication and coordination of services provided by Hospice in the medical record for 1 of 1 resident reviewed for Hospice services (Resident #70). The findings included:	F 849	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this	

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Resident #70 was admitted to the facility on 03/15/23. His diagnosis included cerebral infarction, hypertension, tachycardia, neurogenic bowel, and anemia.

A Weekly Hospice note dated 08/04/23 for Resident #70 revealed Hospice Nurse (SN) visit for facility patient with diagnosis of hemiplegia following cerebral infarct affecting left side. Upon visit, the patient is in bed with head elevated. He is nonverbal and contracted in all extremities, with no signs or symptoms of pain or distress. He does blink and occasionally will track with his eyes when spoken to. He is frail and his skin is fragile and has an air mattress in use. Foam boots on feet. His trach is intact, with clear frothy sputum noted on gown, with tube feeding infusing, and his urine catheter was in place with yellow mucous urine in tubing. The patient's safety was maintained, and Activities for Daily Living (ADLs) were provided by facility staff and Hospice Aide (HA).

A review of Resident #70's Quarterly Minimum Data Set dated 09/15/23 indicated Resident #70 was severely cognitively impaired and needed total assistance with activities for daily living (ADLs).

A review of Resident #70's care plan dated 09/15/23 identified Resident #70 had a progressive decline, and Hospice care was provided due to progressive decline. The resident had a tracheostomy with risk for complications including decreased oxygenation, infection, nutritional imbalance, and decreased ability to communicate due to respiratory distress, and was receiving Hospice services related to terminal

F 849

plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

F849 The facility failed to maintain communication and coordination of services provided by Hospice in the medical record for 1 of 1 resident reviewed for Hospice services (Resident #70).

1. Corrective action for resident(s) affected by the alleged deficient practice:
On 11/2/2023 the HIM uploaded Hospice Services documentation completed by the assigned Hospice nurse for Resident #70 into the medical record.
On 11/2/2023 the uploaded Hospice services documentation was reviewed by the Director of Nurses and the Interdisciplinary Team for coordination of care with the Hospice Nurse.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.
On 11/21/2023 the HIM reviewed the medical record for those residents receiving hospice services for the past 30 days to assure that documentation of Hospice Services was present in each Hospice resident's medical record. The results included:
Seven residents- October and current November notes have been uploaded

On 11/21/2023 the interdisciplinary team

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F 849	Continued From page 52 condition. A review of Resident #70's Electronic Medical Record (EMR) from 08/04/23 through 11/01/23 revealed no documentation or evidence of Hospice services. The last documented Hospice note for Resident #70 was dated 08/04/23. An interview on 11/02/23 at 1:40 PM with the Director of Nursing (DON) revealed that it was her expectation that Hospice should have communicated more fully to facility staff as well as provided Hospice Nurse's complete visit documentation prior to leaving the facility and did not. She said Hospice failed, per their Hospice agreement dated 01/01/2016, to communicate and coordinate of services provided by facility personnel and Hospice personnel and the providing of Hospice services 24-hours per day. And failed to provide Resident #70's Hospice information from Hospice to the facility, which included resident assessments, vital signs, medications, care plan updates, physician order updates or notifications, discussions with facility nursing staff, nursing notes, and Hospice physician orders. The DON said it was her expectation that there be a complete verbal and paper communication process between Hospice and her nursing staff, and there was not. An interview on 11/02/23 at 1:45 PM with the facility Administrator revealed that it was expectation that the Hospice Nurse follow the Nursing Facility Hospice Services Agreement dated 01/01/2016 to provide information from Hospice to the facility to include: "The Hospice Patient Care Coordinator will coordinate all aspects of patient care by assuring an adequate exchange of information and facilitating	F 849	and Hospice nurse(s) met to assure coordination of care was in place for each Hospice Resident. 3. Systemic changes. The Administrator, Director of Nurses, Health Information Manager, Hospice Nurse(s) and Interdisciplinary team were educated by the Quality Assurance Nurse Consultant on 11/20/2023 of the expectation that Hospice Services provided to residents will be documented and uploaded into the medical record following the provision of services. As well the Interdisciplinary Team and Hospice Services will review the services being provided for coordination of care for the resident between Hospice and the facility. This will be completed by 11/21/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will audit provided Hospice Services to assure that documentation of Hospice Services is present in the resident record and that review of documentation is done by the Interdisciplinary Team and Hospice to assure coordination of care weekly x 2 and monthly x 3 or until resolved. The Director of Nursing will report to the Quality Assurance Performance Improvement Committee any findings, identified trends, or patterns. Any negative finding will be corrected at the time of discovery in accordance to the standard.	

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F 849	Continued From page 53 communication and interaction among the Inter Disciplinary Group (IDG) and family, and Nursing Facility personnel." The Administrator revealed that the facility and their Hospice provider failed to communicate or share Resident #70's documentation with facility's nursing staff, which was not available to facility staff on a 24-hour basis per Hospice agreement. An interview was conducted on 11/02/23 at 1:50 PM with Nurse #7 (Hospice Nurse). She stated the resident was visited weekly by her and 3-times per week by a Hospice Aide. She stated the resident was being well cared for by her and the facility's nursing staff. And if further assistance was needed, the facility could reach her 24/7 by phone. The Hospice nurse revealed that not all her notes or complete Hospice documentation had been provided to the facility to scan into their electronic medical record. She said it was her expectation that Resident's #70 complete Hospice medical records be available to facility staff on a 24-hour, 7-days per week, per facility agreement, and were not. The Hospice nurse agreed that a complete communication structure should have been set up (verbal and written form) between the facility and Hospice staff, and present at the facility, and was not. She said she kept most of the resident's orders, assessments, and notes on her computer. It was her expectation, that from now on, she would print off resident #70's complete visit notes, assessments, updated orders, timely for Medical Records to scan them into the facility's EMR system. She said she would also document after each visit, a visit summary electronically and place it in the resident's electronic medical chart, titled "Hospice Note".	F 849	The Performance Improvement Committee consists of the Administrator, Director of Nursing, RN supervisor, Minimum Data Set Coordinator, Activities Director, Dietary Manager, Maintenance/Housekeeping Director, Medical Director and the Director of Social Services. Date of Compliance: 12/15/2023	

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F 849	Continued From page 54 An interview on 11/02/23 at 2:00 PM with Medical Records #1 revealed that it was her expectation that Resident #70's complete Hospice medical records be available to staff on a 24-hour, 7-days per week, per facility agreement, and were not. The Hospice nurse agreed that a complete communication structure should have been set up (verbal and written form) between the facility and Hospice staff, and was present at the facility, and was not.	F 849		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		12/15/23

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§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its

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performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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F 867	Continued From page 57 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility's Quality Assessment and Assurance (QAA) program failed to maintain implemented procedures and monitor interventions the committee put in place following the recertification and complaint investigation survey completed on 7/15/22 and the recertification survey completed on 05/03/21. This was for three repeat deficiencies originally cited in the areas of accuracy of assessments (F641), Label/Store Drugs and Biologicals (F761), and Food Procurement, Store/Prepare/Serve - Sanitary (F812). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F641: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of 1) nutritional status (Resident #66), 2) skin conditions (Resident #88), and 3) urinary continence (Resident #86) for 3 of 26 residents whose MDS assessments were reviewed. During the recertification and complaint investigation survey of 7/15/22 the facility failed to	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/29/2023 the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation (CI) survey conducted on 7/15/2022 and recertification survey completed on 5/3/21. This was for 3 deficiencies that were cited in the areas of accuracy of assessments (F641), Label/Store Drugs and Biologicals(F761), and Food Procurement, Store/ Prepare/Serve-	

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F 867	Continued From page 58	F 867		

accurately code the Minimum Data Set (MDS) in the area of activities of daily living assistance.

During the recertification and complaint investigation survey of 05/03/21 the facility failed to accurately code the quarterly Minimum Data Set (MDS) assessments in the areas of prognosis, falls, wander/elopement alarm, and medications.

F761: Based on observation and staff interview the facility failed to discard expired bottles of medication that were stored in the Rehab medication cart for 1 of 3 medication carts inspected.

During the recertification and complaint investigation survey of 05/03/21 the facility failed to report an equipment failure of a medication dispensing machine and dispose of expired medications.

F812: Based on observation and staff interviews the facility failed to clean 1 of 3 ice machines used to provide ice for residents (300-400 hall ice machine).

During the recertification and complaint investigation survey of 05/03/21 the facility failed to replace abraded bowls, to remove grease and filters above the stove/oven system, label unopened food, discard compromised pans and remove stains from coffee mugs.

In an interview with the Administrator on 11/02/23 at 4:07 PM he stated he thought the previous plans of correction failed due to a lack of communication and a lack of auditing for correctness. He noted both of these aspects

Sanitary (F812). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain effective QAA program.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
•Corrective action has been taken for the identified concerns in the areas of: accuracy of assessments (F641)
•Corrective action has been taken for the identified concerns in the areas of: Label/Store Drugs and Biologicals (F761)
•Corrective action has been taken for the identified concerns in the areas of: Food Procurement, Store/Prepare/Serve-Sanitary
The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 11/29/23 to review the deficiencies from the 10/30/23 – 11/2/23 annual recertification survey, CI survey, and reviewed the citations.
On 11/ 20 /2023, the Regional Operations Director and Regional Clinical Consultant in-serviced the facility administrator and the Quality Assurance Committee on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
Education:
On 11/ 22/ 2023 the administrator completed in-servicing with the QAPI team members that include the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345468	A. BUILDING ______ B. WING ______	C 11/02/2023

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F 867	Continued From page 59 would be implemented in the new plans of correction. He also noted he would be consulting other sister facilities for plan of correction ideas.	F 867	Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 12/15/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting,	

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F 867	Continued From page 60	F 867	indefinitely or until no longer deemed necessary for compliance with the missing laundry process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 12/15/2023	